Harbourside Family Practice
Dr. Peter O'Donnell, MD

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name:_____ DOB: _____
Address:_____ Phone: _____
_____ SSN: _____

I hereby authorize _____
(your previous doctor or practice that has your records)

Address _____ Ph_____
_____ Fax_____
or their authorized employees to disclose protected health information to:

Harbourside Family Practice
60 Forest Falls Drive
Yarmouth, ME 04096
Ph (207) 846-2229
Secure Fax (207) 560-9409

I AUTHORIZE THIS RELEASE FOR THE FOLLOWING REASON:

- ☐ Transfer of Care ___All Records_____
- ☐ Communication with other providers, specialists, or consultants __(Not Transferring)_____
- ☐ Other (please specify) _____

I understand that my medical record contains information relating to my diagnosis and treatment, and authorize the release of all such information including information relating to drug and/or alcohol abuse, psychiatric treatment, sexually transmitted disease or other sensitive information except for those items I specify.

I do NOT authorize release of:

- ☐ Drug and/or Alcohol treatment records
- ☐ Psychiatric treatment records
- ☐ STD testing records (including HIV status)

I understand that I have the right to revoke this authorization, in writing, at any time and this authorization expires one year from date signed.

_____ _____
Signature of Patient or legal guardian Date