Julius Damion, M.D.

144 US Route One, Scarborough, Maine 04074
Phone: 207-774-2113 Fax: 207-774-9165

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I hereby authorize the following health care provider: DISCLOSURE PURPOSE: RECORD TRANSFER TO NEW PROVIDER

Julius Damion, M.D 144 US Route One, Scarborough, Maine 04074 to

release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Protected health information to be released:

Medical records (specify, can state "all") _____

Time Frame: __ entire record __ records from _____(date) to _____(date)

Your specific permission is required to disclose information regarding the following:
Check box and sign to specify protected health information to be disclosed

☐ Yes ☐ No I authorize the release of my HIV test results or status, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
(Maine law requires our practice to inform you that, if this information is misused, disclosing your HIV infection status may have consequences, such as negative treatment in your personal life or by insurance companies. It can be important for providing you needed services and healthcare.)

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ _____

Expiration: This authorization becomes effect immediately and shall expire on: _____
If no date is given, this authorization is valid for **30 months** from signature date.

- I understand that I am not required to sign this form and Julius Damion, M.D. will not condition treatment, payment for services, or eligibility for services on whether I sign this form. I understand that my refusal to sign may result in improper diagnosis or treatment, denial of coverage for health benefits or other insurance or other adverse consequences.

- I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.

- I understand that I have the right to access or copy the PHI described in this form by making a written request to the Privacy Officer of this practice. A copying fee may be charged as permitted by law.

- I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance of this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer at Julius Damion, M.D. I understand that revocation may be the basais of denial of health benefits or other insurance coverage or benefits.

- I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws.

- I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.

- I understand that I have a right to receive a copy of this authorization.

Signed:_____ Date: _____

Print Name:_____

If signed by other than patient, indicate legal relationship: _____