Independent Health Advantage

Authorization to Use, Disclose, and Obtain Health Information

Patient Name:_____ DOB: _____

I hereby authorize Independent Health Advantage, PLLC ("IHA"), located at 7 Payneton Hill Rd., York, Maine 03909, and its authorized agents to obtain the following health information from _____ for the purpose of continuity of medical care:

☐ **All medical records** from the date signed on this release, including without limitation: physician notes, specialist notes, medications and allergy lists, laboratory results, radiology and endoscopy reports, EKG tracings, echocardiogram reports, stress test results, spirometry and sleep study data, hospital admission and discharge summaries, operative notes, advanced directives, controlled medication agreement, and medical marijuana certification.

☐ Or, specific time period: ___/___/_____ to ___/___/_____.

Consent is required to disclose the following types of health information. By checking the adjacent boxes, I specifically authorize IHA to obtain the following types of information.

☐ Mental health treatment records. (If I want to review my mental health records before they are released, I must check this box ☐. I understand that the review will be supervised.)

☐ Genetic testing

☐ HIV/AIDS and sexually transmitted disease test results and treatment records. (I understand that authorizing the disclosure of this information could have adverse consequences if the information is misused. This may include discriminatory treatment, whether lawful or unlawful. I understand that IHA will protect the confidentiality of information about my HIV status, sexually transmitted disease status, and all my healthcare records, as the law requires.)

☐ Alcohol/drug abuse treatment records

I intend this authorization to include the disclosure for records and information that the disclosing facility or provider has received from other healthcare providers or facilities. I authorize that subsequent disclosures of information within the scope of this authorization may be made pursuant to this same authorization.

This authorization shall expire 1 year from the date of my signature below, unless revoked by an earlier expiration date here:

_____

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By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of the above healthcare information. My refusal may result in improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance, or other adverse consequences. IHA will not condition my ability to receive healthcare services or treatment on providing or refusing to provide this authorization.
- I may revoke this authorization at any time, either orally or in writing, by notifying IHA's Privacy Officer at 207-703-5365. Revoking this authorization will not apply to information that was already used/disclosed/obtained in reliance on my having signed this form.
- The health information that is disclosed pursuant to this authorization may be subject to re-disclosure by recipient, and it may not be possible to protect the privacy of this information once re-disclosed.
- I have the right to make a written request to review my records before signing. I have the right to receive copies of my records for a reasonable fee.
- I have a right to a copy of this signed authorization.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use and disclosure of my Health Information. By my signature below, I hereby knowingly and voluntarily authorize IHA to obtain, disclose, and/or use, disclose my Health Information in the manner described above.

_____ _____

Signature of Patient *or, if Patient is incapacitated, Patient's legal guardian or authorized representative*

Date

_____

If signed by a legal guardian or authorized representative, description of authority or relationship (e.g. healthcare power of attorney, healthcare surrogate)

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<u>Important Legal Information</u>:

HIPAA

HIPAA entitles every person the right to access his or her medical records, receive copies of them, and request amendments to them. HIPAA allows providers 30 days to complete a record request. It also allows a single 30-day extension, but the facility must explain the cause of the delay.

Maine Statute 1711-A. <u>Fees charged for records</u>

Whenever a health care practitioner defined in section 1711-B furnishes in paper form requested copies of a patient's treatment record or a medical report or an addition to a treatment record or medical report to the patient or the patient's authorized representative, the charge for the copies or the report may not exceed the reasonable costs incurred by the health care practitioner in making and providing the copies or the report. The charge for the copies or the report may not exceed $5 for the first page and 45¢ for each additional page, up to a maximum of $250 for the entire treatment record or medical report. [2013, c. 158, §3 (AMD).]

If a treatment record or medical report exists in a digital or electronic format, the health care practitioner shall provide an electronic copy of the treatment record or medical report if an electronic copy is requested and it is reasonably possible to provide it. The health care practitioner may assess as charges reasonable actual costs of staff time to create or copy the treatment record or medical report and the costs of necessary supplies and postage. Actual costs may not include a retrieval fee or the costs of new technology, maintenance of the electronic record system, data access or storage infrastructure. Charges assessed under this paragraph may not exceed $150. [2013, c. 158, §3 (NEW).]