MAINE FUNCTIONAL MEDICINE

Mail form to: Maine Functional Medicine, 22 Parkway South, Box 100, Brewer, ME 04412

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____

Previous Name: _____ Social Security # _____

Contact Number: _____ Address: _____

I request and authorize **Maine Functional Medicine, formerly at 33 PENN PLAZA, SUITE A BANGOR, ME 04401** to release healthcare information of the patient named above to:

Name, address, fax #, phone #:

_____

_____

_____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates (ex. Last 2 years)

_____

_____

☐ All healthcare information (Check only this box it you want all of your records to be sent)

☐ Other: _____

Definition: Sexually Transmitted Disease (std) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (acquired immunodeficiency syndrome), and gonorrhea.

CHECKING THESE BOXES NO WILL RESTRICT THE INFORMATION SENT

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, 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.

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

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED