AUTHORIZATION FOR TREATING PROVIDER TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This authorization is for the use or disclosure of health information pertaining to:

Name: _____

Address:_____

DOB : _____ Phone: _____

☐ I authorize the release to ☐ I authorize the release from

Medical Professionals Health Program (MPHP),
P.O. Box 69, Manchester, ME 04351
Phone: (207) 623-9266 Fax: (207) 430-8386

To *release* my protected health information to and obtain information from:

Name: _____

Agency (if applicable): _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Information to be released:

☐ I authorize the release of a summary statement which may contain the following: protected health information (including demographic information), MPHP program status, and information about my physical health or conditions

☐ I authorize the release of information related to substance use and toxicological screens

☐ I authorize the release of HIV/AIDS status

☐ I authorize the release of information regarding psychiatric diagnosis (including DSM and/or ICD-9 code) provided to the Medical Professionals Health Program by my evaluation or treatment providers.

☐ Psychiatric/psychological evaluation (to apply to participants advocates only. i.e. legal representation) provided it is not stamped “do not re-release”

☐ Other (Please be specific. Ex: return to work, coordination of care, etc):_____

Expiration: This authorization becomes effective immediately and shall expire on: _____ (up to 5 years). I understand that I may withdraw this release in writing at any time.

- I understand that authorizing the disclosure of protected health information is voluntary, and that I can refuse to sign. Also, I may inspect or copy the PHI that is the subject of this authorization before the entity I am authorizing discloses the PHI. 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 I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on 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 the practice I have authorized to disclose information. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.
- I understand that protected health information used or disclosed pursuant to this authorization may no longer be protected by federal or state health privacy laws, but may be protected by other confidentiality laws.
- I understand, due to the limitations noted to me and which I signed off on in the MPHP informed consent, some information must be shared with the licensing board regardless of whether or not a release of information is in place. This information which can be released is limited **only to** the information on the MPHP informed consent form.
- I understand that I have a right to receive a copy of this authorization.

Signed: _____ Date: _____

Printed Name: _____

MPHP Staff Signature: _____ Date: _____