MMA SAMPLE FORM
REVIEW CAREFULLY & ADAPT TO YOUR PRACTICE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

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

Name: _____*[Practice or Patient Fills out with Patient Contact Information]*_____

Address:_____

DOB : _____ MRN: __*[Optional]*_____ Phone: _____

I hereby authorize the following health care provider:

_____*[Add your practice name &contact information here]*_____

_____

To *release* my protected health information to:

Name: _____*[Patient or practice fills out where information will be sent]*

Address: _____

Purpose of disclosure:
[If practice is using PHI for marketing purposes, this must be stated & include if remuneration is involved]

Protected health information to be released:

- ☐ Medical records (specify, can state "all"):_____
- ☐ Billing records

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

- ☐ Treatment by Mental Health Professional or Program _____

[Note to practice: this includes records generated at a mental health agency/facility or by a psychiatrist, clinical nurse specialist, social worker or psychologist; records created by other physicians do not require specific authorization]

- ☐ Drug/Alcohol Abuse _____

[Note to practice: this includes records generated by medical personnel whose primary function is providing alcohol or drug abuse diagnosis, treatment, or referral and who are identified as such providers, not general care providers]

- ☐ HIV Test Results or Status _____

(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 & healthcare.)

- Continued –

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Expiration: This authorization becomes effective immediately and shall expire on: _____.
If no date is given, this authorization is valid for **30 months** from signature date.
[*If mental health facility/agency/program, replace "30 months" with "one year")*

- I understand that I am not required to sign this form and [*enter practice name]* 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: *[Enter practice Privacy Officer name/contact information]*. A copying fee may be charged as permitted by law. [*If mental health agency/facility/program, add: I have a right to review mental health records prior to the release of those records, within 3 working days of my request.]*
- I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken in 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 *[enter practice name]*. I understand that revocation may be the basis for 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: _____

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