**HARRINGTON FAMILY HEALTH CENTER  
50 E. MAIN ST., HARRINGTON, ME 04643 PHONE: 207-483-4502 FAX: 207-483-2750**

**AUTHORIZATION TO RECEIVE MEDICAL RECORDS FROM AN OUTSIDE CLINICIAN/FACILITY**

**DATE:\_\_\_\_\_\_\_\_\_ PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_**

**PATIENT PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the \_\_\_\_Patient, \_\_\_\_Legal next of kin, or \_\_\_\_Legal Guardian for the patient, hereby authorize Harrington Family Health Center, its employees and agents to receive information from the medical records of the patient listed above. These records may be copied and mailed, faxed, or electronically transmitted from the physician/facility.**

**PHYSICIAN/FACILITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE RELEASE ANY OF THE FOLLOWING INFORMATION THAT HAS BEEN CHECKED BELOW**

**\_\_\_\_ALL RECORDS  
\_\_\_\_IMMUNIZATIONS ONLY  
\_\_\_\_Medical Problems—Please give specific types/dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_OTHER—Please specify; including dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE INITIAL APPROPRIATE BOX BELOW FOR RELEASE OF SPECIFIC CATEGORIES OF INFORMATION**

**YES\_\_\_\_ NO\_\_\_\_ PSYCHIATRIC/PSYCHOLOGICAL PROBLEMS  
YES\_\_\_\_ NO\_\_\_\_ CHEMICAL/ALCOHOL DEPENDENCY  
YES\_\_\_\_ NO\_\_\_\_ AIDS/HIV TESTING and/or TREATMENT OF STDS**

**REFUSAL TO DISCLOSE ALL OR SOME HEALTH CARE INFORMATION MAY RESULT IN IMPROPER DIAGNOSIS OR TREATMENT AND/OR DENIAL OF COVERAGE FOR HEALTH BENEFITS OR OTHER ADVERSE CONDITIONS.**

**The purpose of this disclosure is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I UNDERSTAND THAT I MAY REVIEW RECORDS WTH SUPERVISON  
I UNDERSTAND THAT THIS AUTHORIZATION EXPIRES 12 MONTHS FROM THIS DATE AND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME PRIOR TO THE EXPIRATION DATE BY NOTIFYING HFHC IN WRITING, SIGNED AND DATED. I ALSO UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of Patient or Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Witness Date**