York Hospital

15 Hospital Drive - York, Maine 03909

PHONE - (207) 363-4321

FAX (207) ____________

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

MR# 000140187 DEPT. ____________

NAME: Cassidy Bortner D.O.B. 2/4/99

ADDRESS: Kittery Me TELEPHONE #: ____________

1. I authorize and request the release of the medical records obtained in the course of treatment at (name of hospital): York Hospital
   for the time period of: 11/9/00
   to be furnished to: State Police New Hampshire Jill Rocke
   for the purpose of: ___ Continued Care ___ Insurance ___ Personal Use ___ Other (Please Specify)
   Investigation

2. The specific information to be disclosed is:

___ Discharge Summary	___ X-Ray Reports	___ Entire Medical Record
___ History & Physical	___ X-Ray Films	___ Pathology Report
✓ ER Records	___ Cardiology Reports	___ Face Sheet
___ Operative Record	___ Lab Reports	___ Pain Management
___ Physical Therapy Notes	___ Oncology Reports	___ Nurses Notes
		___ Birthing Records

___ Statements I have added to my treatment records, with responses, if any
___ Other (Please Specify) ER Records,

3. This authorization to release information expires thirty (30) months from today's date of __/__/____. I understand this consent is subject to revocation at any time by my signed and dated written notice to the Patient Records Staff except for actions that have already been taken in reliance thereon.

4. If my initials appear here _____, I understand that the medical record contains information about drug abuse, alcohol abuse, and/or psychiatric treatment. I do herein expressly and voluntarily consent to disclosure of the medical record information for the purpose or need as stated above.

5. If my initials appear here _____, I understand that the medical record contains information about testing for the HIV Antibody or Antigen. I voluntarily consent to disclosure of the information contained in my medical record for the purpose or need as stated above.

6. **A photocopy of this authorization shall have the same effect as the original.** I am entitled to a copy of this document.

7. If my initials appear here _____, I am exercising my right to refuse authorization to release health care information, although refusal could result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.

8. I have carefully read and I understand the above statements, and do voluntarily consent to this and future disclosures regarding these records to the same above-named individuals or agencies during this time period. The person/agency receiving this information has been informed that any redisclosure of this information, without my further consent, is prohibited by law. This information is required as my physical and psychological status is an issue in certain legal proceedings

Jill C. Rockey 696 — Signature of patient, parent (or other agent for patient)

Janet R. Jones RN — Signature of witness

___-___-___ NHSP-A
Social Security #(optional)
603-679-3333

11/9/00 @ 18:00
Date