

AUTHORIZATION TO RELEASE MEDICAL RECORDS

MR# 000 140177

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 MAINE STATE ERIC
 for the purpose of: Continued Care Insurance Personal Use Other (Please Specify)
Investigation BARC

2. The specific information to be disclosed is:

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> Entire Medical Record
<input type="checkbox"/> History & Physical	<input type="checkbox"/> X-Ray Films	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> ER Records	<input type="checkbox"/> Cardiology Reports	<input type="checkbox"/> Face Sheet
<input type="checkbox"/> Operative Record	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Pain Management
<input type="checkbox"/> Physical Therapy Notes	<input type="checkbox"/> Oncology Reports	<input type="checkbox"/> Nurses Notes
<input type="checkbox"/> Statements I have added to my treatment records, with responses, if any		<input type="checkbox"/> Birthing Records
<input type="checkbox"/> Other (Please Specify) <u>ER Records</u>		

3. This authorization to release information expires thirty (30) months from today's date of 11/9/00. 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

[Signature] 657-5710
 Signature of patient, parent (or other agent for patient)

[Signature] RN
 Signature of witness

Social Security # (optional) _____

Date 11/9/00