

Consent to Obtain Information

Pine Tree Pediatrics, 131 Franklin Health Commons, Suite L, Farmington, ME 04938

Phone (207) 778-0482, Fax (207) 778-0133

A Program of Franklin Memorial Hospital

I, _____, authorize Pine Tree Pediatrics, its employees and agents to **OBTAIN** the
(Patient/Parent/Guardian)
following information about _____, DOB _____, from

Address of Releasing Individual or Entity: _____

Phone Number: _____

Please forward: (Check all that apply)

- Office Notes Lab Results Immunizations
 EKG/X-Ray Results Hospitalization Summaries All Records
 Records from other facilities Other: (Please specify) _____
 Records Dated from _____ to _____

This information disclosure may be used for: _____.

I **DO** **DO NOT** authorize the release of any information relating to the diagnosis or treatment of an **HIV INFECTION** under this authorization.

I **DO** **DO NOT** authorize the release of any information relating to the diagnosis or treatment of **ALCOHOL OR DRUG ABUSE** under this authorization. If I authorize the release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent.

I **DO** **DO NOT** authorize the release of any information relating to the diagnosis or treatment of **MENTAL HEALTH** under this authorization. If I authorize the release of this information, I **DO** **DO NOT** want to review this information before its release. I understand that any such review must be supervised.

My consent to release these records is effective until _____ (not to exceed 90 days) and I **DO** **DO NOT** authorize subsequent disclosures regarding these records during this time.

I understand that:

- I may revoke all or part of this authorization at any time by notifying the releasing individual or entity orally, or in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation.
- I may refuse to disclose all or some of the information in my medical records.
- A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- I may have a copy of this form upon request.
- I may cross out any words on this form with which I disagree.

SIGNED: _____ Relationship to Patient: _____ Date: _____

Address: (Street address/Town/State) _____

Phone: _____