



NEW ENGLAND WOMENCENTER

260 Western Avenue, South Portland, Maine 04106
Tel: 207-761-4700 Fax: 207-761-4744

www.newenglandwomencenter.com

Susan Doughty RN, MSN, WHNP-C

Authorization for Use or Disclosure of Health Information

I, _____(your name), hereby voluntarily authorize disclosure of information from my medical record. The purpose of this disclosure is to permit coordination of care.

I permit the following parties to share information:

New England WomenCenter
260 Western Avenue
South Portland, ME 04106
Phone: 207-761-4700
Fax: 207-761-4744

and

Name: _____

I would like the following information to be disclosed from my medical record:

Entire Record

Only information related to (specify):

Only for events in the time period of:

Other (specify):

I authorize the release the following sensitive health information:

Mental health care, including psychotherapy notes

HIV-AIDS related treatment

Alcohol or drug treatment or consultation

I understand that my medical record contains information about my identity, history, and diagnosis.

I understand that I may revoke this authorization at any time by submitting a request in writing to New England WomenCenter, except to the extent that action has already been taken based on my previous consent. If I do not revoke this authorization, it will remain in effect for one year from the date of my signature, or until the following expiration date:

_____ (optional).

I have read this form and I certify that I understand its contents.

Patient signature: _____

Date: _____

Witness signature: _____

Date: _____