



NEW ENGLAND WOMENCENTER ¹

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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 <u>Name:</u> _____ _____ _____ _____
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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: _____