UNIVERSITY OF MAINE AT PRESQUE ISLE
181 Main Street, Presque Isle, ME 04769-2888

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please print legibly:

I authorize the UMaine-Presque Isle Health Center to disclose and discuss medical records and patient information about _____.
Patient Name

DOB_____, to _____
(receiving individual or entity)

The information to be disclosed includes:
_____
_____

This information may be used for ___ financial ___medical ___personal Other: _____

I understand UMaine-Presque Isle needs my specific consent to release the following type of information:

__I authorize __I do not authorize UMPI to release information which refers to treatment or diagnosis of HIV related diseases. I understand that individuals about whom such disclosures have been made may have encountered discrimination from others in the areas of employment, housing, education, life insurance and social/family relationships.

If not previously revoked, this authorization will expire on _____.
Date (not to exceed twelve (12) months)

I also understand that:

- Future disclosures regarding these records may be made to the same individual or entity described in this consent until it expires.
- I can revoke all or part of this authorization at any time by notifying the Director of the Health Center at UMPI in writing, except for information that may have been disclosed before my revocation. I understand that refusal or revocation of permission may result in improper diagnosis or treatment, denial of health benefits or insurance, or other adverse consequences. Revocation will not affect information already given out.
- I can review my medical records and refuse to disclose all or some of the information in them.
- Partial or incomplete records will be labeled as such.
- I can have a copy of this consent form upon request.

_____	_____	_____
Date	Witness	Signature of Patient
_____	_____	_____
Date	Witness	*Parent, legal guardian, durable power of attorney or other authorized representative

*A parent or guardian is generally required to sign for a patient under the age of 18. Patients aged 14-17 should also sign. If an adult is unable to make or communicate medical decisions, then the following may sign in the priority given; agent under healthcare power of attorney, guardian, spouse, next-of-kin. Indicate capacity of representative.