The Village Doctor
Benjamin G. Newman, MD
729 Summer Harbor Rd., P.O. Box 158
Winter Harbor, ME 04693
207-963-2001 Fax: 888-719-5860

**Authorization for Release of Health Care Information**

I,____________________________________________________________Date of Birth______________________
Address:_______________________________________________________Phone:
Authorize: Name of Practice _____________________________________________________________________
Address: _______________________________________________________________________________________
City: _____________________________________________________State:__________Zip Code______________

To Release/Disclose the specified information noted below to:

Benjamin G. Newman, MD
P.O. Box 158
Winter Harbor, ME 04693 Phone: 207-963-2001 Fax: 1-888-719-5860

My health care records from____________to_____________or my entire health care record. (circle **entire health care record** if that is your request)

Purpose of requested disclosure: At the Request of the Individual________

Other:_____________________________________________________________
(Please Specify)

Release only: (write in specific parts of the record: i.e., lab reports, physician notes for date or dates)

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Circle “Yes” if you want the following information released.
Circle “No” if you do not want it released.

**1.** Alcohol or drug dependency, evaluation, diagnosis or treatment records. YES NO
**2.** Mental health evaluation and treatment records, except psychotherapy notes (I understand that I have the right to review this information under supervision before it is released and I hereby inform you that I do not wish to review that information YES NO
**3.** HIV/AIDS test results, diagnosis, status, or treatment records. YES NO

I understand that information disclosed under this authorization might be re-disclosed recipient, and that any such re-disclosure may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization at any time. I understand I cannot revoke this authorization if ______________________________________has taken action on the authorization. Authorization will be considered inactive when ___________________________________________________receives a request in writing to revoke authorization.

I understand that I may refuse authorization to release all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.

This authorization for release is effective for the release of the medical information mentioned above to the named recipient only.

This authorization will expire onor upon the following event_______________________________________________________

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that I have the right to receive a copy of this authorization.

Signature of Patient___________________________________ Date signed_____________

Signature of Witness___________________________________ Date signed_____________