Date Received: _____

Wiscasset Family Medicine

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____ Apt. # _____
City: _____ State: _____ Zip Code: _____ Ph# (___) _____

I hereby authorize the release of copies of my medical records concerning my illness, treatment or recommendations while I was a patient at the medical facility, during the dates of: _____

These records should be released:

From:
Name: _____ Phone Number: _____
Address: _____ Fax Number: _____
_____

To:
Wiscasset Family Medicine, LLC.
P.O. Box 351 / 66 Water St.
Wiscasset, Maine 04578

Phone Number: (207) 882-6008
Fax Number: (207) 882-7803

I request the following information be released:

_____ Inpatient hospital record ____ ER/ First Care Visit _____ X-Rays or EKG _____ Lab/Path report
_____ Clinical Offices (specify) _____ _____ Other (specify) _____
_____ Abstract (choose for personal use, and continuation of care) _____ Complete Copy (used for legal purposes)

Please initial the following specific authorizations: [Required by law]:

_____ AIDS/HIV and other Communicable Disease
_____ Alcohol and/or Drug Abuse Treatment
_____ Mental Health Services provided by: A clinical nurse specialist; Psychologist; Social Worker; counseling professional; or a physician specializing in psychiatry licensed under the provision of Title 32.

Purpose of disclosure: (Check applicable purpose)

☐ Transfer of Care ☐ Continued Medical Care ☐ Other: _____

I understand I may revoke all or part of this authorization by notifying Wiscasset Family Medicine. This authorization will be retained as part of my medical record. I may refuse to disclose all or some of the information in my medical record. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or claim for health benefits, or other adverse consequences. I may cross out any words on this authorization with which I disagree. I may have a copy of this authorization upon request. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. If I refuse to sign this authorization I understand my records will not be released.

This authorization will expire 90 days from the date I sign this form.

_____ _____ _____
Signature of Patient or Legal Representative | Relationship to Patient | Date

Wiscasset Family Medicine may take up to 30 business days to complete requests. If picking up records, please bring a photo ID.

Charges are as follows for the processing of medical records:
Paper copies - $5 for the first page and $0.45 per page following, up to a maximum of $250 for the entire treatment record or medical report.
Digital or Electronic copies - $50 flat rate fee.

There are no charges for provider to provide care. We accept checks, money orders, Visa or MasterCard.