Authorization to Release Health Care Information

(22 M.R.S.A. § 1711-C(3) and 45 CFR §164.508(c) (HIPAA))
This authorization complies with both the Maine Statutes and HIPAA requirements.

Anatomical Donor Program

Please complete this form only if you are willing to release your medical records at time of death to the Anatomical Donor Program.

I, ____ have donated my body to the University of New England, College of Osteopathic Medicine, Anatomical Donor Program, for educational, research, and scientific purposes.

In order to increase the educational, research, and scientific value of my donation following my death, I authorize and request any health care facility in which I was a patient at any time within two (2) years prior to my death, and any physician who at any time attended me within two (2) years prior to my death to furnish to any representative of the University of New England Anatomical Donor Program, any and all records concerning my case history, treatment and examination which I may have received. I release any such physician or health care facility from any and all responsibility or liability that may arise from this authorization.

Specific Authorization

By circling I DO this means that if this information is documented in your medical record you DO have my authorization to include a copy of it in response to the request for medical records. By circling I DO NOT this means if the information is documented in the records, you do NOT have authorization to release the records.

1. I (DO) (DO NOT) (N/A) authorize release of information which refers to treatment of diagnosis of mental health.
2. I (DO) (DO NOT) (N/A) waive my right to review reports regarding psychiatric illness before they are released.
3. I (DO) (DO NOT) (N/A) authorize release of all records of any other health care provider in the possession of the above named provider.
4. I (DO) (DO NOT) (N/A) authorize release of information which refers to treatment or diagnosis of substance (drug or alcohol) abuse. Such information may not be re-disclosed by the recipient without my specific consent.

* *

I UNDERSTAND:

I may revoke all or part of this authorization at any time by executing a written revocation and delivering it to the practitioner or facility holding this authorization, subject to the rights of any person who relied on the authorization before he or she received my revocation. This revocation will be signed and dated by me and will state that all or part of this authorization is revoked.

I am entitled to authorize disclosure of health care information, and if I refuse or if I revoke the authorization, I understand that such refusal or revocation may result in a lack of information for the Anatomical Donor Program. I understand that treatment or my participation in the Anatomical Donor Program will not be denied if I refuse to sign this authorization.

This authorization shall be effective until revoked by me or another as provided in 22 M.R.S.A. § 1711-C(5) or for 30 months from the date signed, whichever comes first. I understand that such revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

A photocopy of this authorization may be used in lieu of the original. Subsequent disclosures by you and other disclosures by other health care providers may be made under this authorization.

(Form continues on reverse)

_____ _____

Signature Date

_____

Mailing Address

_____ _____

City, State, Zip Phone

_____ _____

Date of Birth Social Security Number

_____

Name of Primary Care Physician

_____

Mailing Address City, State, Zip

_____

Telephone #

All medical information will remain confidential and used only for educational, research, and scientific activities.