



NEW ENGLAND Cancer Specialists

Authorization for Release of Health Information

I, _____ ; DOB: ____ / ____ / ____ (_____)
Patient Name Date of Birth Maiden Name

Authorize:

I authorize New England Cancer Specialists to obtain my medical records from other healthcare providers for the purpose of providing medical care to me, and I authorize the release of my medical records to other healthcare providers for the same purpose.

Disclose to:

New England Cancer Specialists
105 Topsham Fair Mall Rd
Topsham, Maine 04086
Phone: (207)729-1148
Fax: (207)729-2789

Any health information and records of any treatment or examination rendered to me:

(Fill in Time Frame) From: _____ To: _____

√ *A check mark will indicate permission to release information.*

___ Alcohol or drug dependency records

___ Mental Health Treatment Records – Specific diagnosis

___ HIV / AIDS Antibody Test Results and Diagnosis/Treatment Records

___ Genetic Information (Including Genetic Test Results)

- I understand that once this information is released, my physician and/or his/her employees cannot prevent the re-disclosure of that information. I release New England Cancer Specialists and any of its employees from any and all liability arising directly from disclosure authorized by this consent and any re-disclosure of that information.
- I understand I have the right to revoke this authorization at any time. Authorization will be considered inactive when New England Cancer Specialists receives a request in writing to revoke the authorization.

This authorization for disclosure is effective for one year from the date signed.

Signature of Patient

Date

Signature of Legal Representative

Date

Authority to Act – Legal Representative:

Legal Guardian Spouse of Deceased Executor of Estate Health Care Power of Attorney