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
2 Independence Dr.
Kennebunk, Maine 04043
Phone: (207)985-0008
Fax: (207)985-9820

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