MAINE NATURAL MEDICINE

Empowering Health™

HIPAA Authorization Form

Patient's Full Name | **Patient Email Address**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   Maine Natural Medicine, 63 Foster Street, Suite 2, Ellsworth, Maine, 04605
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Maine Natural Medicine
   His/her/its Name

   63 Foster Street, Suite 2
   Address

   Ellsworth, Maine 04605
   City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

__X__**ALL MEDICAL RECORDS INCLUDING: LABS, TEST RESULTS, OFFICE VISIT NOTES, CONSULTATIONS, AND DIAGNOSES FOR THE CALENDER YEAR** .

You can choose to disclose information about alcohol/substance abuse, HIV/AIDS, or mental health. NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED WITHOUT YOUR CONCENT:
YES, DISCLOSE THIS INFORMATION *_____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Maine Natural Medicine in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. This authorization expires on the 31st of December of the calendar year in which it was signed.
7. **FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.**
8. **THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING**

_____ | _____ | _____
Signature of Individual* (The person about whom the information relates) | **Date of Individual's Signature** | **Date of Birth**

OR, if applicable –

_____ | _____ | _____
Signature of Guardian* or Personal Representative of Patient's Estate | **Date of Guardian's/Personal Representative's Signature** | **Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Office Use Only

_____ | _____ | _____
Received | **Processed By** | **Log #**

MARLY SACHSMAN, ND, MA-CCC
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