FULCRUM FAMILY HEALTH

RELEASE OF HEALTH CARE INFORMATION REQUEST

Name of Patient: _____ Date of Birth : _____

Dates of Service: _____ Social Security #: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above-named patient.

Patient information is needed for:

_X_ Continuity of Care

Information to be released or accessed:

_X_ History and Physical	X Consultation Report	X Emergency Room Record
_X_ Operative Reports	X Discharge/Death Summary	X Face Sheet
_X_ Lab/Path Reports	X Xray Reports/Images	X Other: _____

The above information may be released:

TO: **Fulcrum Family Health, Dr. Lisa Lucas**
174 S Freeport Road, Suite 1A Freeport, ME 04032
Phone: (207) 386-4895, Fax: (207) 835-4091

FROM:

Doctor, Hospital: _____ Phone#: _____

Address: _____ Fax #: _____

- I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include by not limited to history, diagnosis and/or treatment of drug and alcohol abuse, mental illness or communicable disease, including HIV or AIDS.
- I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon my authorization.
- The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____ _____

` Patient or Legally Authorized Name/Relationship to Patient (if different from above)