# Medical Records Release and Authorization
# For Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____

SSN: _____ Date of Birth:_____/_____/____

I authorize the custodian of records to disclose/release the following information:

_____ _____

**(Enter name of physician or practice)** **(Phone & Fax Number)**

Patient Chief Complaint For Records: _____

**(Enter Qualifying Condition)**

☐All records ☐Laboratory/pathology records ☐X-ray/radiology records ☐Billing records
☒Abstract/Summary ☐Pharmacy/prescription records
☒ Office Notes – Diagnosis and Treatments Including Med List
**☒ Most Recent Physical Exam or Office Visit including VITALS and CLINICAL SUMMARY**

☐ All dates ☒ These records are for services provided on the following date(s): Last 3 Months

My specific authorization is necessary to release information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse, and or HIV/AIDS status. I understand that I have the right to review any mental health information before release of such information. I authorize the release of potentially sensitive information.

☒ Mental Health (including anxiety and depression) ☒ Substance Abuse ☒ HIV/Aids

Reason for Request: ☒ Consultation ☐ Transfer Of Care

Please send the records listed above to
☒ Dustin Sulak, D.O. and/or
170 US Route 1, Suite 200
Falmouth, ME 04105
Phone 207-482-0188
Fax 1- (888) 642-8601

This authorization shall expire 12 months from the date hereof unless an earlier date or event is stated here:_____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. When required, I authorize Integr8 Health, LLC providers to discuss my case with the above provider. A copy of this authorization is available on request.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to Sign (parent, guardian, power of attorney for healthcare, executor)

*You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the custodian of records listed above.*