Metabolic Leader, LLC, PA
51 U.S. Route One, Suite H
Scarborough, ME 04074

PHONE (207) 396-6433
FAX (207) 396-6436

www.metabolicleader.com

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____
(Please Print)
Patient's Address: _____

Patient's Telephone Number: _____ Social Security # _____ _____

From: _____
_____
_____

To: Metabolic Leader
51 US Route One, Suite H, Scarborough, ME 04074
Tele # (207) 396-6433; Fax # (207) 396-6436

____ I authorize release of **all** medical information.
____ I authorize release of eye exam information.
____ I authorize release of information from appointments on _____ (date) to _____ (date).

I request the following information be released *(last three years unless otherwise specified):*

□ Annual Exams	□ Office Visits	□ Consultation Reports	□ Progress Notes
□ Lab Results	□ Procedure Reports	□ Ultrasound Report	□ Operative Reports
□ MRI/Cat Scans	□ All Records	□ Eye Exam	□ Other _____

I understand my specific consent is required by state law to release related information that may be contained in the above records:

Mental Health	□ I ***DO*** Authorize	□ I ***DO NOT*** Authorize
Mental Health Services	□ I ***DO*** Authorize	□ I ***DO NOT*** Authorize
Alcohol and Substance Abuse	□ I ***DO*** Authorize	□ I ***DO NOT*** Authorize
HIV/AIDS	□ I ***DO*** Authorize	□ I ***DO NOT*** Authorize

Purpose of Disclosure: □ **For PCP** □ **Transfer of Care** □ **Other:** _____

Duration of Authorization:
This Authorization will expire on _____ (specify date no later than 1 year from date of signing or receipt of revocation)

You may refuse to authorize disclosure of some or all of your healthcare information. You will not be denied treatment unless your healthcare is solely for the purpose of creating health information for another person or entity pursuant to this authorization. However, your refusal may result in improper diagnosis or treatment, denial of coverage or a claim of health benefits/insurance or other adverse consequences. You may revoke this authorization at any time except to the extent that we have already taken action in reliance on it. Your revocation must be in writing and must be signed and dated by you and will be effective when received by our office. Revocation may result in denial of your health benefits or other insurance coverage or benefits. Your health information disclosed in accordance with this Authorization may be re-disclosed by the person or entity authorized to receive it. You are encouraged to contact the person or entity authorized to receive your health information to determine whether and to what extent your health information may be re-disclosed and your right to restrict further disclosures. The disclosures authorized by this Authorization are in addition to and not in limitation of the disclosures of your health information that are authorized by law and applicable regulations. You have a right to receive a copy of this Authorization.

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Patient's Personal Representative:
[ ] Legal Guardian [ ] Health Care Power of Attorney [ ] Parent of Minor Patient [ ] Personal Representative of Deceased Patient
Attach copy of power *Attach copy of Certificate of Appointment*