DOWNEAST ORTHOPEDIC ASSOCIATES ● 78 RIDGEWOOD DRIVE ● BANGOR, ME 04401

Patient Information:

Name:_____**DOB:**_____

- **I am requesting health information is released ☐ to ☐ from :**

☐	**Stephen Walsh, MD**	**307-8901 – Phone**	**307-8911 – Fax**
☐	**Garrett Martin, MD**	**307-8902 – Phone**	**307-8912 – Fax**
☐	**Jacob Brooks, DO**	**307-8903 – Phone**	**307-8913 – Fax**
☐	**Thompson McGuire, MD**	**307-8904 – Phone**	**307-8914 - Fax**
☐	**Kenneth Morse, MD**	**307-8905 – Phone**	**307-8915 – Fax**
☐	**P. Gregory Askins, MD**	**307-8906 – Phone**	**307-8916 – Fax**
☐	**John Pyne, MD**	**307-8907 – Phone**	**307-8917 – Fax**
☐	**Cameron Trubey, MD**	**307-8908 – Phone**	**307-8918 – Fax**

- **I am requesting health information be sent ☐ to ☐ from :**

Organization/Clinic Name:_____

Mailing address:_____

City::_____**State:**_____**Zip Code:**_____

Fax:_____**Phone:**_____

The specific information I want disclosed includes:

☐ All health information pertaining to:_____

OR *only* release indicated records pertaining to:_____

☐	Office visit notes	☐	Laboratory reports	☐	Operative reports
☐	Therapy notes	☐	EMG report	☐	Imaging/Radiology reports
☐	Other:_____				

I understand that by signing this form, I am requesting that the health information specified be sent to myself or the third party listed above. I may revoke all or part of this authorization at any time by notifying the medical provider in writing, subject to the rights or anyone who received or disclosed information prior to receiving my revocation. I may refuse to disclose all or some of the information in my medical records. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences. I may have a copy of this form upon request.

This release applies only to information concerning diagnosis and treatment rendered on this date. Information may be released for up to 30 months from the date this release was signed.

SIGNED: _____ **Date:** _____

(patient or his/her legally appointed representative)

Updated 11/2013