

Timothy Allen, M.D.
Surgery of the Hand
Tel: 207.307.8906
Fax: 833-496-1905

78 Ridgewood Drive Bangor, ME 04401
downeastortho.com



Jacob Brooks, D.O.
Cara Savage, P.A.-C.
Karis Filteau, P.A.-C.

Orthopedic/Arthroscopic Surgery
Tel: 207.307.8903
Fax: 833-496-1914

P. Alex Green, M.D.
Surgery of the Hand &
Upper Extremity
Tel: 207.307.8909
Fax: 833-496-1907

Jessica Lucas, D.O.
Primary Care Sports Medicine
Tel: 207.307.8951
Fax: 833-496-1909

Garrett R. Martin, M.D.
Valerie Attia, P.A.-C.
Adult Reconstructive Surgery
Tel: 207.307.8902
Fax: 833-496-1918

D. Thompson McGuire, M.D.
Orthopedic Sports Medicine
Tel: 207.307.8904
Fax: 833-496-1910

Kenneth Morse, M.D.
Orthopedic Sports Medicine
Tel: 207.307.8905
Fax: 833-496-1911

John Pyne, M.D.
Surgery of the Hand
Tel: 207.307.8907
Fax: 833-496-1908

Cameron Trubey, M.D.
Primary Care Sports Medicine
Tel: 207.307.8908
Fax: 833-496-1909

Elizabeth Truelove, M.D.
Surgery of the Hand
Tel: 207.307.8906
Fax: 833-496-1905

Tony J. Tsismenakis, M.D.
Adult Reconstructive Surgery
Tel: 207.307.8910
Fax: 833-496-1915

Stephen M. Walsh, M.D.
Misti Guerin, F.N.P.-C.
Adult Reconstructive Surgery
Tel: 207.307.8901
Fax: 833-496-1916

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name (Please Print): _____ **DOB:** _____

As specified below, I hereby authorize DownEast Orthopedics and its authorized employees and agents to:

- Release medical records to (Patient; legal guardian, medical provider):
- Obtain medical records from (Medical provider):

Organization/Clinic Name: _____

Mailing address: _____

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

Fax: _____ **Phone:** _____

Records to Be: **Mailed:** **Faxed:** **Picked up:**

Emailed to: _____

The specific information I want disclosed includes:

All health information pertaining to (Specify body part): _____

OR only release indicated records pertaining to (Specify body part): _____

- Office visit notes Laboratory reports Operative reports
- Therapy notes EMG report Imaging/Radiology reports
- Other (Please specify): _____

Dates of Service (Example – last 3 years): _____

This disclosure is for the purpose of: _____

My specific permission is required to disclose information regarding HIV test results or status. I understand that authorizing the release of such information does not confirm the existence of such history or treatment.

Check one of the options below and initial at end to confirm your choice:

- I DO authorize disclosure of information which refers to HIV test results, infection status or treatment information. **Intials:** _____
- I DO NOT authorize disclosure of information which refers to HIV test results, infection status or treatment information. **Intials:** _____

I understand that:

- ◆ I am not required to sign this form and that I may refuse to disclose all or some of the above healthcare information in my treatment records, but that refusal may result in improper diagnosis or treatment, denial of coverage for a claim for health benefits, denial of other insurance, or other adverse consequences.
- ◆ PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.
- ◆ I further understand that I may withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing.
- ◆ PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by confidentiality laws.
- ◆ I am entitled to a copy of this authorization, upon request.

EXPIRATION: This authorization becomes effective immediately and shall expire one year from the date of signing.

SIGNED: _____ **Date:** _____

(patient or his/her legally appointed representative)