MAINE MOBILE HEALTH PROGRAM
PATIENT'S REQUEST TO RELEASE OR OBTAIN HEALTH CARE INFORMATION

PATIENT NAME/NON PASYAN: _____

DOB/DAT NESANS: _____

ADDRESS/ADRÈS: _____

_____

_____

INFORMATION TO BE RELEASED TO/LAGE ENFÒMASYON BAY:
(check whichever one applies/tcheke chak ki bon nan sityasyon sa-a)

{ } I request and authorize / *Mwen mande e otorize:*
_____(Provider) /*(Travayè Medikal)*
to **release** my health care information, including my medical records, **TO** the following entity
*enfòmasyon swen sante mwen, dosye medikal mwen ladan sa-a, **BAY NAN** kote sa-a ki ekri anba:*

Name of Organization/NON ÒGANIZASYON: _____
Location of Organization/LOKALTE ÒGANIZASYON: _____

_____

Telephone Number/NIMEWO TELEFON: _____

OR/OUBYEN

{ } I request and authorize _____(Provider) to **receive** my
Mwen mande e otorize _____ *(Travayè Medikal) pou **resevwa***
health care information, including any medical records, **FROM** the following entity:
*enfòmasyon swen sante mwen, dosye medikal mwen ladan sa-a, **SOTI NAN** men kote sa-a ki ekri anba:*

Name of Organization/*NON ÒGANIZASYON*: _____
Location of Organization/ *LOKALITE ÒGANIZASYON*: _____

_____

Telephone Number/*NIMEWO TELEFON*: _____

TYPE OF INFORMATION TO BE RELEASED/KALITE ENFÒMASYON KI SIPOZE LAGE:

General Release (limited to one (1) year of information unless otherwise requested).
Lage Jeneral (konsène enfòmasyon nan en (1) an, si lòt kantite tan pa demande).

Type of Record/KALITE DOSYE	Date(s) of Disclosure/Dat (yo) Demande
{ } Entire Medical Record (excluding protected information) *Dosye Medikal Komplet (Enfòmasyon pwoteje pa ladan)*	____/____/____ to ____/____/____
{ } Discharge Summary *Papye ki esplike vizit medikal la e kisa pou fè apre*	____/____/____ to ____/____/____

{ } Lab Results (list each request below)/*Rezilta (ekri tout sa ki mande anba)* ____/____/____ to ____/____/____

{ } History & Physical/*Istwa & Physik* ____/____/____ to ____/____/____

{ } X-Rays/*Radiographie* ____/____/____ to ____/____/____

{ } Operative Report/*Rapò Operasyon* ____/____/____ to ____/____/____

{ } Consultation Report /*Rapò Konsiltasyon* ____/____/____ to ____/____/____

{ } Other Report/*Lòt Rapò* ____/____/____ to ____/____/____

PROTECTED INFORMATION/*ENFÒMASYON PWOTEJE*

PATIENT'S REQUEST TO RELEASE OR OBTAIN HEALTH CARE INFORMATION/*PASYAN MANDE POU LAGE OUBYEN JWENN ENFÒMASYON SWEN SANTE*

{ } Substance Abuse/*Abizman Dwòg ou lòt bagay* ____/____/____ to ____/____/____

{ } Mental Health/*Sante Mental* ____/____/____ to ____/____/____

{ } Communicable Disease/*Maladi kontamine* ____/____/____ to ____/____/____

{ } HIV/*VIH* ____/____/____ to ____/____/____

In the space below please state any additional information relevant to the release/ *nan espas sa-a make tout lòt enfòmasyon ki empòtan e mache ansanm avek demache sa-a*

_____

_____

_____

_____

Mwen konprann, mwen gen dwa revoke otorizasyon sa-a nenpòt kile. Mwen konprann, si mwen revoke otorizasyon sa-a, fòk mwen fè sa-a nan lèt ekri, e mennen bay li nan men Travayè Pwogram Sante de Migran Men ki anchaj Pwogram Prive. Mwen konprann enfomasyon ki deja lage nan men pwogram avek otorizasyon sa-a pap chanje. Mwen konprann otorizasyon sa-a pou bay enfòmasyon sante se yon bagay volontè. Mwen konprann nenpòt enfomasyon ki lage ka gen chans li lage anko san otorizasyon e enfomasyon ka pa pwoteje anba dwa prive federal.

_____ _____

Signature of Patient or Patient's Legal Representative Date/*Dat*

Non pasyan ekri kole oubyen moun ki reprezantif legal pasyan

If Representative, please explain relationship to patient/Si reprezantif, tanpri esplike relasyon ou avek pasyan:

_____

{ } Check here if you wish the Maine Mobile Health Program to fax information./*Tcheke isit si ou vle*

Pwogram Sante de Migran Men voye enfòmasyon ou avek machin fax.

Fax Number: _____

Poutèt kesyon de konfidansyalite, nou pa renmen voye enfòmasyon sante ou avek machin fax, paske nou pa ka konnen l'ap rive nan fax kote ki sipoze rive, oubyen si enfòmasyon ki rive nan machine sa-a , ap ret sou machin oubyen pa.