**Authorization to Release Protected Information**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_**

 **Send Information From: (Request Information From) Send to: (Head Start Program Address)**

 Promise Early Education Center

 269 Bates Street, Lewiston, ME 04258

 Fax# **888-502-1522**

Attn: Norma Larocque

###

 **Please check the records you would prefer:**

|  |  |
| --- | --- |
| * **Most Current Records**
 | * **Dental Records**
 |
| * **Physicals/WCC**
* **Immunizations**
* **Lead/HGB/HCT/Labs**
 | * **Office visits**
* **Medication/Prescriptions/Appliances**
 |
| * **Surgical Services (discharge summary, consults, radiology, Care Plans)**
 | * **Home Health (Plan of care, orders, visit notes)**
 |
| * **Emergency Department**

**(discharge summary, care plan)**  | * **Other (Consent to Speak)**
 |

**Please Circle**

 authorized disclosure of any information relating to the diagnosis and/or treatment of **Mental Health ­­** **\_\_ Do \_\_ Do Not**

 authorized disclosure of information which refers to **HIV, Infection Status and/or Treatment \_\_ Do \_\_ Do Not**

##

##  authorize disclosure of any information relating to Alcohol and/or Drug Abuse \_\_ Do \_\_ Do Not

##

##  Reason records are needed (check all that apply)

###  For Head Start Health Requirements Personal Use Other:

**I understand that:** I do not have to sign this authorization for Promise Early Education Center. I can refuse to disclose some or all information in my record. I can revoke all or part of this authorization at any time. I understand I am entitled to a copy of this authorization at any time.

 **Written statement that I want to revoke my authorization should be delivered to:**

 Promise Early Education Center, 269 Bates St., Lewiston, ME 04254 ATTN:

 This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual

 and/or entity during this time period pursuant to this authorization.

**Date Signature of Parent/guardian**

 **Authorization to Release Protected Information-How to use**

 **Most Current Records**

 Records come from Health Information department (medical records) of hospital systems i.e. CMMC / St. Mary’s

 Records from Pulmonology, ENT/Audiology, other specialty offices. Usually a one-time request or records that come from visits scheduled at intervals. Can be used with Office Visits for intervals that can be requested directly from provider office as needed

 **Physical/WCC** **Immunizations** **Lead/hgb/hct**

 These records come straight from Health Information (Medical records). There is no other conversation that can be had based on this request. Must choose Other for office visit consult or questions re: information on physicals or any other office visit… This is the way to have interoffice conversation for parent support or consult for a child’s need.

 **Surgical Services-**

 This could be the same as Hospital (discharge summary, consults, care plans)

 **Emergency Dept**-

 Records from ER visits as needed for family support

 **Dental Records**-

 Any dental provider records. Must choose Other for verbal support services and follow up

 **Office Visits**  **Medication, Prescription**

 This covers sick child visits or other office visits that may require a return to school note.

 Medication maybe used to talk about any clarification or pharmacy release we may need. Prescription

 may cover eye wear or hearing appliances as needed.

 **Home Health** –

 Providers, case management or home health and care plans that may be supported by PEEC staff

 **Other**- \*crucial for Promise Health staff

 This is the check off that allows for interoffice conversations or any odd/unusual interaction with providers.

This release was created to cover the specifics of HIPPA as Hospital systems require for the release

of records. They are now very specific on how they interpret our requests.