



Heidi M. Larson, M.D.  
*Family Practice*

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

I authorize \_\_\_\_\_ to disclose protected health information (PHI) from the health records of:

Patient name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Patient medical record number (or DOB): \_\_\_\_\_

I authorize PHI from \_\_\_\_\_ to \_\_\_\_\_ to be disclosed to

**Heidi M. Larson, M.D.**  
**190 Pine Street Portland ME 04102**  
**207-874-0022 Fax 207-874-2122**

**Specific description of the information to be disclosed:**

- \_\_\_\_\_ discharge Summary      \_\_\_\_\_ Records from Previous Physician
- \_\_\_\_\_ History and Physical Exam      \_\_\_\_\_ Consultation Reports
- \_\_\_\_\_ Operative Reports      \_\_\_\_\_ Progress Notes/Office Notes
- \_\_\_\_\_ Diagnostic Tests
- \_\_\_\_\_ Other (specify) \_\_\_\_\_

**Specific description of the purpose of the disclosure:**

- \_\_\_\_\_ Continued Patient Care
- \_\_\_\_\_ Workers' Compensation
- \_\_\_\_\_ Insurance Coverage or Payment for Care
- \_\_\_\_\_ Other (specify) \_\_\_\_\_

**OR**

\_\_\_\_\_ The disclosure is at my (the patient's) request.

**I authorize the provider to use or disclose information related to (check all that apply)(this element often required by State Laws):**

- \_\_\_\_\_ AIDS/HIV and other Communicable Disease
- \_\_\_\_\_ Behavioral Health Care/Psychiatric Care/Mental Health Information
- \_\_\_\_\_ Alcohol and/or Drug Abuse Treatment

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_