Authorization to Release Certain Protected Health Information Related to Insurance Status

This authorization is for the disclosure of Protected Health Information (PHI) related to insurance status for: *[Enter Patient Name and Contact Information]:*

Name: ____

Address: ____

Phone: _________________

I authorize this health care provider: ____________________________________
To release my contact information, including name, address and telephone number to:

Name: ________Maine Equal Justice Partners_______________________
Address: ______126 Sewall Street, Augusta ME 04330________________

How will my protected health information be used? Maine Equal Justice Partners (MEJP) is a legal aid and advocacy organization that is advocating for Medicaid expansion under the Affordable Care Act. MEJP is looking for people who may benefit from Maine expanding Medicaid coverage and will contact you about how you may be able to help.

Protected Health Information to be released:
- ☑ Contact information including name, address and telephone number
- ☑ Other: insurance status

Expiration: I want my consent to end on: ___ Month ____Day ____Year.
If I leave this blank, my consent will end in two years (24 months)

I understand that:

- I am not required to sign this form and________________________________ will not condition treatment, payment for services, or eligibility for services on whether I sign this form.
- I have the right to access or copy the protected health information described in the form by making a written request to the Privacy Officer of the practice. A copying fee may be charged as permitted by law.
- I have the right to 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 and present my written revocation to the Privacy Officer at ________________________________.
- I understand that protected health information used or disclosed pursuant to this authorization may be disclosed by the recipient and no longer protected by confidentiality laws.
- I have a right to receive a copy of this authorization.

Signed: ____ Date: _________________

Print name: ____

If signed by other than patient, indicate legal relationship: _____________________________