Penobscot Community Health Care
Medical Records
P.O. Box 439
Bangor, ME 04402-0439
(207) 404-8101 Fax (207) 990-1248

Patient Name: _____

Patient Address: _____

Date of Birth: _____

Patient Phone: _____

Authorization to Obtain Prescription History

I authorize Penobscot Community Health Care and Its Affiliated Providers to view external prescription history via the Surescripts service and other prescription history providers for _____.
(Patient Name)

I understand that these organizations may obtain prescription history going back several years from outside (non-PCHC) medical providers, insurance companies, and pharmacy benefit managers.

I have read this Authorization form and I understand it. By signing this consent form I agree that Penobscot Community Health Care can request and use my or the patient's prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes, and I release PCHC, its employees, directors, officers and medical staff, from legal responsibility or liability for the release of the Medical Information.

Signed: _____ Date: _____
(Patient or Representative)

If not signed by the Patient, please indicate the authority to act for the patient:

☐ Parent ☐ Guardian ☐ Power of Attorney [*Please attached proof of authority if signing as a guardian or under a power of attorney.]*

This Authorization Form is voluntary and you may refuse to sign it. You may also cross out any words on this form that you do not agree with. Refusal to sign the form will not block your ability to receive health care services or payment for services; except that refusing to sign will mean you will not receive health services if those services are only to provide your Medical Information to someone else which requires a signed Authorization form. Refusal to sign this form may cause improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other negative outcomes.

You may have a copy of this form if you wish. In addition, you may inspect or receive a copy of the information requested in this form for a fee. The current prices are available where you receive care or by calling Medical Records at (207) 404-8101. The requested information will be sent within thirty (30) days of when you submit a completed form and pay the fee.

- If you ask that copies of the requested information be sent by mail, PCHC will send that information on a compact disc unless you have given other instructions.
- If you ask for e-mail copies of the information, you must provide a valid e-mail address. Your records will be given as Adobe PDF files on PCHC's secure messaging portal. PCHC will send an email to the email address you provide with instructions on how to access your Medical Information through the secure messaging portal.

You can cancel or stop this form at any time by sending a written request to PCHC at the above address. If you cancel this Authorization, it will not stop or change any actions already taken by PCHC prior to receiving your notice to cancel. Canceling this form can cause denial of health benefits or other insurance coverage or benefits, or lead to incomplete prescription history which may jeopardize your care.

PCHC Use Only:

Received By: _____ Location: _____ Date: _____

Rev. 8/15/2016