HARRINGTON FAMILY HEALTH CENTER
50 East Main Street
HARRINGTON, ME 04643
PHONE (207) 483-4502 ~ FAX (207) 483-4778

PRIVACY NOTICE

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS AND /OR NON-RELATED PERSONS

I have received a copy of Harrington Family Health Center's Privacy Notice.

I_____the___Parent___Legal Guardian of _____
Date of Birth_____, hereby authorize Harrington Family Health Center (HFHC), its staff and its affiliates, to furnish professional and medical information about the above named patient to the person(s) named below. Such information may include, but is not limited to, information about lab results, diagnosis, treatment plan and prognosis. I hereby release HFHC, its staff, and its affiliates from all liability, legal or otherwise, that may arise from the release of information by HFHC, its staff and its affiliates.

In the event of a minor aged 14 years or older requesting privacy regarding family planning, drug or alcohol abuse, or sexually transmitted diseases, by law we are not required to release said information to a parent or legal guardian.

This release is valid for one calendar year from the date of signing, and may be revoked at time by the Parent/Guardian, as long as the Parent/Guardian provides such request in writing.

I authorize the release of information to the person(s) named below:

Name/Relationship	Name/Relationship
_____	_____
_____	_____
_____	_____
_____	_____

By signing below, the person signing indicates that he/she has read this policy and agrees to it. He/she also attests to the fact that he/she has been given the opportunity to ask questions about this policy and that the questions have been answered to his/her satisfaction.

SIGNATURE OF PARENT/GUARDIAN	DATE
_____	_____

AN EQUAL OPPORTUNITY EMPLOYER AND PROVIDER