Mast Clinic, Inc

Helping Children to Be Their Best
980 Forest Ave, Suite 100, Portland, ME 04103
Mailing address: 94 Rackleff St, Portland, ME 04103
Phone 207 689 6278 Fax 207 747 4107
info @ mastclinic.com

HIPAA Authorization to Release Protected Health Information (PHI)/Physical Therapy Records

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your child's records to be shared as requested.

Patient's full name:_____Date of birth:_____

Parent(s)/Guardian(s) Name(s)_____
Mailing address:
Street address or PO Box_____

City_____-_____State_____Zipcode_____

Phone_____ email address_____

Authorization:

I_____ hereby authorizeMast Clinic, Inc. to release

_____'s protected health information/physical therapy records to:
__parent(s)/guardian(s)
__healthcare provider- name_____ address_____

Which records are requested?: *records will be paper copies*
initial examination report__
progress reports__
discharge report__
treatment notes (handwritten)__
all past and present records__

What is the date range of the patient's medical records being released? From to

This authorization is effective immediately and shall expire on___
If no date is given, authorization is valid for 6 months from the date this form was signed. After the expiration date, a new signed authorization form for request of records. Until 12/31/2024, authorization forms can be requested by emailing info@mastclinic.com
Requests will be filled as per time limitations dictated by state law retention requirements.
If requested records have not already been sent, parent(s)/guardian(s) can rescind this consent for release of protected health information/physical therapy record by written request mailed to: Mast Clinic , 94 Rackleff St, Portland ME 04103

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I agree to pay $5 for the first page and 45¢ for each additional page, up to a maximum of $250 for Mast Clinic's physical therapy records__ *(initial)*

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law __*(initial)*

Signature_____ printed name_____

Date_____

Please mail this form to Mast Clinic, 94 Rackleff St, Portland, Maine 04103