



110 Broadway – Bucksport, ME 04416  
37 Commerce Park – Ellsworth, ME 04605  
(207) 469-7371    [www.bucksportrhc.org](http://www.bucksportrhc.org)

## Welcome to Bucksport Regional Health Center!

We are pleased that you have chosen Bucksport Regional Health Center for your healthcare services. Our staff is committed to providing you with an exceptional experience in service and quality care. At BRHC, we provide patient-centered and team-based care. You will have a team of people who collaborate closely with your provider to meet your healthcare needs. We want you to feel comfortable asking questions and participating in your care to help you have the best experience possible.

To help our providers understand your needs and provide exceptional care to you, please complete the following enclosed or attached documents prior to your first appointment and return them to Bucksport Regional Health Center ~ 110 Broadway, Bucksport, Maine 04416. Please Note: If you are requesting both medical and dental services, both Release of Information forms must be completed and signed.

- Patient Registration & Information Form
- Health History Form
- Authorization to Obtain Health Information – Medical
- Authorization to Obtain Health Information - Dental
- Patient Informed Consent for Telehealth Services

As a Federally Qualified Health Center, Bucksport Regional Health Center offers a Sliding Fee Discount Program for those who qualify. Please call (207) 469-7371 Ext. 253 for further information.

Thank you again for choosing Bucksport Regional Health Center as your health care provider. We hope to have a long and healthy relationship with you.

Sincerely,

Carol Carew, CEO

Enclosures    11-7-2023TLH

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### BUCKSPORT

110 Broadway ~ Bucksport, Maine 04416  
Medical (207) 469-7371, Dental (207) 902-1100

### ELLSWORTH

37 Commerce Park ~ Ellsworth, Maine 04605  
Medical (207) 667-5064



RESPONSIBLE PARTY INFORMATION FOR BILLING		
<input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN		
NAME	DOB	SS #
PHONE (HOME)	(CELL)	
ADDRESS		

HOUSEHOLD INCOME RANGE			
<input type="checkbox"/> \$0 - \$10,000	<input type="checkbox"/> \$30,001 - \$35,000	<input type="checkbox"/> \$55,001 - \$60,000	<input type="checkbox"/> \$80,001 - \$85,000
<input type="checkbox"/> \$10,001 - \$15,000	<input type="checkbox"/> \$35,001 - \$40,000	<input type="checkbox"/> \$60,001 - \$65,000	<input type="checkbox"/> \$85,001 - \$90,000
<input type="checkbox"/> \$15,001 - \$20,000	<input type="checkbox"/> \$40,001 - \$45,000	<input type="checkbox"/> \$65,001 - \$70,000	<input type="checkbox"/> \$90,001 and Above
<input type="checkbox"/> \$20,001 - \$25,000	<input type="checkbox"/> \$45,001 - \$50,000	<input type="checkbox"/> \$70,001 - \$75,000	<input type="checkbox"/> CHOOSE NOT TO DISCLOSE
<input type="checkbox"/> \$25,001 - \$30,000	<input type="checkbox"/> \$50,001 - \$55,000	<input type="checkbox"/> \$75,001 - \$80,000	
# OF PEOPLE LIVING IN HOUSEHOLD:		# OF ADULTS:	# OF CHILDREN:

PREFERRED PHARMACY	
PHARMACY NAME	
PHARMACY ADDRESS	
PHARMACY PHONE #	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)			
<b>PRIMARY INSURANCE</b> (COMPANY)			
POLICY #	GROUP ID #	CO-PAY	
<b>SECONDARY INSURANCE</b> (COMPANY)			
POLICY #	GROUP ID #	CO-PAY	
<b>POLICY HOLDER</b> (NAME)			
DOB	SS #		
PHONE (HOME)	(CELL)		
ADDRESS			

PATIENT INFORMATION-SOCIAL HISTORY	
BRHC WOULD LIKE TO PROVIDE YOU WITH THE BEST CARE AND SERVICES POSSIBLE TO MEET YOUR MEDICAL, DENTAL AND BEHAVIORAL HEALTH NEEDS. TO BETTER UNDERSTAND YOUR NEEDS, WE WOULD LIKE TO KNOW A LITTLE MORE ABOUT YOU. THIS INFORMATION WILL BE KEPT SECURE AS WELL AS ALL OF YOUR HEALTH INFORMATION PER OUR NOTICE OF PRIVACY GUIDELINES.	
ARE YOU A MILITARY VETERAN?	<input type="checkbox"/> YES <input type="checkbox"/> NO
ARE YOU AN AGRICULTURAL WORKER: <input type="checkbox"/> MIGRAINT <input type="checkbox"/> SEASONAL	<input type="checkbox"/> YES <input type="checkbox"/> NO
HOUSING STATUS:	<input type="checkbox"/> NOT HOMELESS <input type="checkbox"/> TRANSITIONAL <input type="checkbox"/> DOUBLE UP <input type="checkbox"/> PUBLIC HOUSING <input type="checkbox"/> SHELTER <input type="checkbox"/> STREET <input type="checkbox"/> HOMELESS (IF HOMELESS, WHERE DO YOU LIVE:) <input type="checkbox"/> OTHER
COMMUNICATION NEEDS	<input type="checkbox"/> NONE <input type="checkbox"/> LIMITED ENGLISH PROFICIENCY <input type="checkbox"/> NEED INTERPRETER
PRIMARY LANGUAGE	<input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER
ARE YOU VISUALLY IMPAIRED?	<input type="checkbox"/> YES <input type="checkbox"/> NO
ARE YOU HEARING IMPAIRED?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IMMUNIZATION DATA PROTECTION ALLOWS YOUR IMMUNIZATION RECORDS TO BE SHOWN ON THE STATE OF MAINE REGISTRY. I AUTHORIZE MY IMMUNIZATION RECORD DATA TO BE SUBMITTED TO THE STATE OF MAINE REGISTRY?	<input type="checkbox"/> YES <input type="checkbox"/> NO

DO YOU HAVE A RELIGIOUS AFFILIATION? IF SO, WHAT AFFILIATION:	<input type="checkbox"/> YES <input type="checkbox"/> NO
EDUCATION: <input type="checkbox"/> SOME HIGH SCHOOL <input type="checkbox"/> GED-HIGH SCHOOL GRADUATE <input type="checkbox"/> TRADE <input type="checkbox"/> SOME COLLEGE <input type="checkbox"/> COLLEGE GRADUATE TECHNICAL/VOCATIONAL	
DO YOU UNDERSTAND YOUR HEALTHCARE NEEDS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE ANY TROUBLE EATING?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU USED DRUGS OTHER THAN THOSE FOR MEDICAL REASONS IN THE PAST 12 MONTHS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
WITHIN THE PAST 12 MONTHS, WE WORRIED WHETHER OUR FOOD WOULD RUN OUT BEFORE WE GOT MONEY TO BUY MORE.	<input type="checkbox"/> YES <input type="checkbox"/> NO
WITHIN THE PAST 12 MONTHS, THE FOOD WE BOUGHT JUST DIDN'T LAST AND WE DIDN'T HAVE MONEY TO GET MORE.	<input type="checkbox"/> YES <input type="checkbox"/> NO
WOULD YOU LIKE TO MEET WITH OUR HEALTH EDUCATOR TO DISCUSS LIFESTYLE CHANGES OR TO ACCESS OTHER HEALTH RESOURCES? <b>NOTE: THERE IS NO CHARGE TO YOU FOR THIS SERVICE.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE (IF APPLICABLE)

\_\_\_\_\_  
DATE



## HEALTH HISTORY FORM

<b>FULL LEGAL NAME</b>		<b>Date of Birth</b>	
<b>Most Recent Primary Care Provider</b>		<u>Last Visit</u>	
<b>Most Recent Dental Provider</b>		<u>Last Visit</u>	<u>Last X-Ray</u>
<b>Have you ever been seen at BRHC before?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>How did you hear about BRHC?</b>		
<b>Provider Preference</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female		

### HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

<input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatment
<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Trouble
<input type="checkbox"/> Yes <input type="checkbox"/> No Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis - Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Skins Rash
<input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Abnormally with Extractions or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No Special Diet
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Feet or Ankles
<input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Neck Glands
<input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis
<input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis
<input type="checkbox"/> Yes <input type="checkbox"/> No Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Tumor-Growth on Head/Neck
<input type="checkbox"/> Yes <input type="checkbox"/> No Cough, Persistent or Bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer
<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No Weight Loss, Unexplained
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Care	

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contact lenses?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke?      If Yes,    How Many Per Day?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink alcohol?    If Yes,    How Many Per Week?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant?      If Yes,    Due Date:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking birth control pills?

**SURGERY - Please indicate any surgeries that you have had.**


**CURRENT MEDICATIONS**


**PHARMACY (Please indicate which pharmacy you use.)**

<b>Name:</b>		<b>Phone Number:</b>	
<b>Address</b>	<b>Town:</b>	<b>State:</b>	



## HEALTH HISTORY FORM

<b>FULL LEGAL NAME</b>	
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ALLERGIES			
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Codeine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetic	_____
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	_____	_____

FAMILY ILLNESS HISTORY	FAMILY HEALTH HISTORY																																																																																								
<i>Please Identify Who</i>	<i>How is the health of your family?</i>																																																																																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 80%; padding: 2px;">Alcoholism</td><td style="width: 20%;"></td></tr> <tr><td style="padding: 2px;">Asthma</td><td></td></tr> <tr><td style="padding: 2px;">Cancer - Breast</td><td></td></tr> <tr><td style="padding: 2px;">Cancer - Colon</td><td></td></tr> <tr><td style="padding: 2px;">Cancer - Prostate</td><td></td></tr> <tr><td style="padding: 2px;">Cancer - Other</td><td></td></tr> <tr><td style="padding: 2px;">Depression</td><td></td></tr> <tr><td style="padding: 2px;">Diabetes</td><td></td></tr> <tr><td style="padding: 2px;">Heart Attack</td><td></td></tr> <tr><td style="padding: 2px;">Heart Problems</td><td></td></tr> <tr><td style="padding: 2px;">High Blood Pressure</td><td></td></tr> <tr><td style="padding: 2px;">Thyroid Problem</td><td></td></tr> <tr><td style="padding: 2px;">Stroke</td><td></td></tr> <tr><td style="padding: 2px;">Other</td><td></td></tr> </table>	Alcoholism		Asthma		Cancer - Breast		Cancer - Colon		Cancer - Prostate		Cancer - Other		Depression		Diabetes		Heart Attack		Heart Problems		High Blood Pressure		Thyroid Problem		Stroke		Other		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 10%;">Good</th> <th style="width: 10%;">Poor</th> <th style="width: 10%;">Died</th> <th style="width: 30%;">Cause of Death</th> </tr> </thead> <tbody> <tr><td style="padding: 2px;">Father</td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;">Mother</td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;">Brother(s)</td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;"> </td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;">Sister (s)</td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;"> </td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;">Children</td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;"> </td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;"> </td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;"> </td><td></td><td></td><td></td><td></td></tr> <tr><td style="padding: 2px;"> </td><td></td><td></td><td></td><td></td></tr> </tbody> </table>		Good	Poor	Died	Cause of Death	Father					Mother					Brother(s)										Sister (s)										Children																								
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Sister (s)																																																																																									
Children																																																																																									

DENTAL HISTORY			
Place a mark on "yes" or "no" to indicate if you have had any of the following:			
<input type="checkbox"/> Yes <input type="checkbox"/> No Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Gums <input type="checkbox"/> Yes <input type="checkbox"/> No Blisters on Lips/Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Burning Sensation on Tongue <input type="checkbox"/> Yes <input type="checkbox"/> No Chew on One side of Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Cigarette/Pipe/Cigar Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No Clicking or Popping Jaw <input type="checkbox"/> Yes <input type="checkbox"/> No Dry Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Fingernail Biting <input type="checkbox"/> Yes <input type="checkbox"/> No Food Collects Between Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No Foreign Objects <input type="checkbox"/> Yes <input type="checkbox"/> No Grinding Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Gums Swollen or Tender <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw Pain or Tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No Lip or Cheek Biting <input type="checkbox"/> Yes <input type="checkbox"/> No Loose Teeth or Broken Fillings <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth Breathing <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth Pain, Brushing <input type="checkbox"/> Yes <input type="checkbox"/> No Orthodontic Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Pain Around Ear	<input type="checkbox"/> Yes <input type="checkbox"/> No Periodontal Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to Cold <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to Heat <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to Sweets <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity When Biting <input type="checkbox"/> Yes <input type="checkbox"/> No Sores or Growths on Mouth	
		How Often do you floss?	
		How often do you brush?	
		Have you had a dental cleaning in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Form Completed By (Name) \_\_\_\_\_

Date \_\_\_\_\_



# Bucksport Regional Health Center

## AUTHORIZATION TO OBTAIN HEALTH INFORMATION

MEDICAL

### INDIVIDUAL WHOSE INFORMATION MAY BE DISCLOSED:

Patient First Name	Patient Last Name	Patient Maiden Name (If Applicable)	Middle Initial
Patient Telephone Number		Date of Birth	
Patient Address		City	State
		Zip Code	

AUTHORIZE	TO DISCLOSE TO
<b>Provider:</b> <b>Practice Name:</b> <b>Address:</b> <b>Phone #:</b> <b>Fax #:</b>	<input type="checkbox"/> Bucksport Regional Health Center <b>MEDICAL RECORDS - BUCKSPORT</b> 110 Broadway - Bucksport, Maine 04416 Phone #: (207) 469-7371 Fax #: (207) 469-7306
	<input type="checkbox"/> Bucksport Regional Health Center <b>MEDICAL RECORDS - ELLSWORTH</b> 37 Commerce Park - Ellsworth, Maine 04605 Phone #: (207) 469-7371 Fax #: (207) 469-7306
<b>Purpose of Release:</b> <input type="checkbox"/> Transfer of Care (Physician Practice Only) <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Shared Medical <input type="checkbox"/> Other _____	<input type="checkbox"/> Bucksport Regional Health Center <b>DENTAL RECORDS - BUCKSPORT</b> 110 Broadway - Bucksport, Maine 04416 Phone #: (207) 902-1100 Fax #: (207) 902-1104 Email: dentalteam@brhcmc.org

### INFORMATION TO BE RELEASED

<input type="checkbox"/> Office Treatment Notes <input type="checkbox"/> History & Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Laboratory <input type="checkbox"/> Pathology	<input type="checkbox"/> Emergency Department <input type="checkbox"/> Consultation <input type="checkbox"/> Operative Report <input type="checkbox"/> Radiology Report <input type="checkbox"/> Homecare & Hospice Reports	<input type="checkbox"/> Psychiatric/Psychological Evaluation <input type="checkbox"/> Psychosocial Evaluation <input type="checkbox"/> Assessment/Care/Plan Notes <input type="checkbox"/> Cardiology <input type="checkbox"/> Vaccinations/Immunizations
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**Additional Information to Be Released**

Dental

Mental Health Treatment Records

Alcohol/Drug Dependency Records - Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

Specific Diagnosis: HIV/AIDS Antibody Test Results & Diagnosis/Treatment

### THE INFORMATION AUTHORIZED TO BE DISCLOSED IS FROM THE FOLLOWING PERIOD(S):

From (mm/dd/yyyy)	To (mm/dd/yyyy)

This Authorization is For:       A One Time Disclosure       Multiple Disclosures

Note: Authorization for disclosure of certain mental health records cannot be continuing authorizations.

I understand I have the right to revoke this authorization at any time. Authorization will be considered null and void when Bucksport Regional Health Center receives a request in writing revoking authorization. This authorization for disclosure is effective for one year from the date signed.

_____ Signature	_____ Date	_____ Relationship to Patient
Authority to Act -Legal Representative: <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Executor of Estate <input type="checkbox"/> Spouse of Deceased <input type="checkbox"/> Health Care Power of Attorney		
_____ Legal Representative Signature	_____ Date	
_____ Witness	_____ Date	



# Bucksport Regional Health Center

## AUTHORIZATION TO OBTAIN HEALTH INFORMATION

DENTAL

### INDIVIDUAL WHOSE INFORMATION MAY BE DISCLOSED:

Patient First Name	Patient Last Name	Patient Maiden Name (If Applicable)	Middle Initial
Patient Telephone Number		Date of Birth	
Patient Address	City	State	Zip Code

AUTHORIZE	TO DISCLOSE TO
Provider: Practice Name: Address: Phone #: Fax #: <b>Purpose of Release:</b> <input type="checkbox"/> Transfer of Care (Physician Practice Only) <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Other _____ <input type="checkbox"/> Shared Medical	<input type="checkbox"/> Bucksport Regional Health Center <b>MEDICAL RECORDS - BUCKSPORT</b> 110 Broadway - Bucksport, Maine 04416 Phone #: (207) 469-7371 Fax #: (207) 469-7306  <input type="checkbox"/> Bucksport Regional Health Center <b>MEDICAL RECORDS - ELLSWORTH</b> 37 Commerce Park - Ellsworth, Maine 04605 Phone #: (207) 469-7371 Fax #: (207) 469-7306  <input type="checkbox"/> Bucksport Regional Health Center <b>DENTAL RECORDS - BUCKSPORT</b> 110 Broadway - Bucksport, Maine 04416 Phone #: (207) 902-1100 Fax #: (207) 902-1104 Email: dentalteam@brhcmc.org

### INFORMATION TO BE RELEASED

<input type="checkbox"/> Office Treatment Notes	<input type="checkbox"/> Emergency Department	<input type="checkbox"/> Psychiatric/Psychological Evaluation
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Consultation	<input type="checkbox"/> Psychosocial Evaluation
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Assessment/Care/Plan Notes
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Cardiology
<input type="checkbox"/> Pathology	<input type="checkbox"/> Homecare & Hospice Reports	<input type="checkbox"/> Vaccinations/Immunizations

Additional Information to Be Released

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Mental Health Treatment Records

Alcohol/Drug Dependency Records - Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

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Signature	Date	Relationship to Patient
Authority to Act - Legal Representative: <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Executor of Estate <input type="checkbox"/> Spouse of Deceased		<input type="checkbox"/> Health Care Power of Attorney
Legal Representative Signature	Date	
Witness	Date	



# CONSENT FORM

**Consent to Treatment.** I authorize Bucksport Regional Health Center (BRHC) and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of BRHC’s medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination.

**Release of Information.** I authorize BRHC to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable BRHC to obtain payment for the services it provides to me; and (3) to permit BRHC to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.

**Assignment of Benefits.** I assign to BRHC all benefits to which I may be entitled from Medicare, MaineCare, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by BRHC.

**Financial Obligations.** I agree that, except as may be limited by law or BRHC’s agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due to services provided at BRHC facilities. I also agree that I am responsible for any applicable co-payments, coinsurance or deductibles.

**Acknowledgment of Receipt of Notice of Privacy Practices.** I acknowledge that I have been offered a copy of the BRHC Notice of Privacy Practices, which describes how health information provided by me may be used and disclosed by BRHC and how I may obtain access to and control the use and disclosure of this information.

**Use of Artificial Intelligence (AI).** I acknowledge and consent to the use of artificial intelligence (AI) technologies by BRHC to assist in clinical decision support, administrative processes, and patient care coordination. I understand that AI tools are used to enhance, not replace, the judgment of qualified healthcare professionals. My health information may be processed by AI systems in compliance with applicable privacy laws and BRHC policies. I have the right to ask questions about how AI is used in my care and may decline AI-assisted services where feasible.

**I have received or declined a copy of the a) BRHC Notice of Privacy Practices, b) Patient’s Rights and Responsibilities, c) Information on the health information exchange including an opportunity to opt out, and d.) plain language summary of the BRHC Financial Assistance Policy.**

These are available at the Front Desk.

**I certify that I have read this form and that I am the patient, or I am duly authorized by the patient as the patient’s representative to execute this form and accept its terms.**

Patient Name (Please Print)	Patient Signature	Date
Representative of Patient	Name/Relationship	Signature
		Date

## BUCKSPORT REGIONAL HEALTH CENTER PATIENT INFORMED CONSENT FOR TELEHEALTH SERVICES

**NONDISCRIMINATION STATEMENT:** Bucksport Regional Health Center (BRHC) and Coastal Health Center (CHC), a practice of BRHC, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language. BRHC and CHC do not exclude people or treat them differently because of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language.

### BRHC & CHC

- Provides free aids and service to people with disabilities to communicate effectively with us, such as:
  - Qualified Sign Language Interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you believe that BRHC or CHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity, or expression, or language, you can file a civil rights complaint with the U.S. Department of Health & Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health & Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

### BRHC PATIENT INFORMED CONSENT FOR TELEHEALTH SERVICES

**What is telehealth and why would I want to use it?** Telehealth uses electronic communication to provide care from a distance (from where you are located) and at the time you need care. It uses equipment that can stream live healthcare visits similar to “face-to-face.” Streaming often occurs through a patient portal that shows your care team on a screen. A patient portal can also be used for written communication with your care team, which is another type of telehealth. Telehealth can be used to assess your weight, blood pressure and other types of monitoring.

**How can telehealth help me?** Your care team can use telehealth to examine, consult, diagnose and treat you. Telehealth can also be used to provide education, help you manage your care and help your plan for your next visit. With telehealth, your care team can work with other providers, including distant specialists. Care using telehealth may be more convenient than in person care.

### MY CONSENT TO USE TELEHEALTH

My healthcare team explained to me the benefits and risks of telehealth, and the types of services that might help me. I understand my provider may use telehealth to examine, consult, diagnose, and/or treat me and that this treatment will be documented in my medical record. I know that I have the right to ask questions and receive guidelines about the services offered to me. My use of telehealth is my choice and no one else can decide that for me. I know I have the right to know who will be involved in my healthcare. This includes the people who will be with me in person and the people

who will be at the distant site to care for me. I know I also have the right to exclude anyone from either site and I have the right to object to the videotaping or other recording of a telehealth service.

I know I can stop using telehealth at any time and request the same service(s) in a face-to-face setting. I know that if I choose the face-to-face services, my care team may change.

I know that information about me may be created, stored, used or disclosed in linking me with the telehealth services. This information is protected health information and will be handled using the standards applied to all protected health information. I know I have the right to access my protected health information under state and federal law.

If I am a MaineCare beneficiary, my refusal of telehealth will not affect my MaineCare benefits. In some circumstances, MaineCare will pay me to travel to receive MaineCare covered services under the MaineCare Benefits Manual.

Permission is given for release of my medical information to provide continuity of care. I understand that I am financially responsible for any part of my bill not paid by insurance.

**Risks:** I know that the computer systems used to deliver telehealth are made to protect others from knowing who I am and/or anything about my health information. Rarely, equipment or security failures can occur despite these protections and my personal information could be exposed. Sometimes, technical problems or the type of health problem being treated result in the transmission of information that is not adequate for medical decision making, which may delay my treatment. In some cases, an in-person visit may be needed.

**Acknowledgement:** My signature below shows that I have read and understand the risks and benefits of telehealth. I have had the chance to discuss telehealth services with my healthcare team and I have no other questions or concerns.

**Patient Consent:** By signing this document, I consent to receive telehealth services.

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**SIGNATURE**

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**I have read this form, or it has been read to me, and I understand it. I understand that I may have a copy on request.**

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Patient Name (Please Print)	Patient* Signature	Date
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Patient Representative* Name/Relationship (Please Print)	Patient*Signature	Date
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**I have received or declined a copy of the a.) BRHC Notice of Privacy Practices, b.) Patient’s Rights and Responsibilities, c.) Information on the health information exchange including an opportunity to opt out, and d.) plain language summary of the BRHC Financial Assistance Policy**

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Patient Name (Please Print)	Patient* Signature	Date
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Patient Representative* Name/Relationship (Please Print)	Patient*Signature	Date
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*\* A parent/guardian or other authorized representative is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should sign in addition to their parent/guardian or authorized representative. Indicate relationship of representative to minor patients.*