Patient Identification

Northern Light
Mercy Hospital

175 Fore River Parkway, Portland, ME 04102

MERCY MEDICAL GROUP PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I give permission to the below Northern Light Mercy Health Center:

- ☐ Dr. Harry E. Davis Pediatrics
- ☐ Internal Medicine, Portland
- ☐ Primary Care, South Portland
- ☐ Primary Care, Windham
- ☐ Primary Care, Gorham Crossings
- ☐ Primary Care, West Falmouth
- ☐ Primary Care, Yarmouth

- ☐ Breast Care
- ☐ Cardiovascular Care
- ☐ Endocrinology and Diabetes Care
- ☐ Gastroenterology
- ☐ Lymphedema Care
- ☐ Orthopedics
- ☐ Physical Therapy
- ☐ Surgery
- ☐ Wound Care
- ☐ Cancer Care
- ☐ Coagulation Clinic
- ☐ Ear, Nose and Throat Care
- ☐ Geriatric Care
- ☐ Midwives
- ☐ Pain Management
- ☐ Spine Surgery
- ☐ Women's Health
- ☐ Other _____

to **VERBALLY** discuss the following medical & billing information about me:

- ☐ Scheduling/appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications & treatment plan
- ☐ Lab/ Test Results
- ☐ Billing, insurance, and payment information
- ☐ Other:

This information may be discussed with the below individual(s):

Name of Practitioner: Location:	Name of Practitioner: Location:
Name:	Name:
Address:	Address:
City/State:	City/State:
Phone:	Phone:

I understand that I have the right to revoke my permission at any time in writing except where Mercy has already made disclosures in reliance upon this request. I understand that I must notify Mercy Medical Group Manager in writing to revoke my permission.

Patient Signature: _____ Date: _____ Time: _____

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SCAN TO CONSENT FORMS

(2/22/23)