Form C - Authorization to Release Information

We are committed to the privacy of your information.
Please read this form carefully.

Which office(s) should help you?

☑ Office of MaineCare Services	☐ Office of Behavioral Health
☑ Office for Family Independence and Medical Review Team	☐ Office of Child and Family Services
☑ Maine Center for Disease Control and Prevention	☐ Office of Aging and Disability Services
☐ Dorothea Dix Psychiatric Center	☐ Office of Administrative Hearings
☐ Riverview Psychiatric Center	☐ Other:
☐ Division of Licensing and Certification	☐ Other:

Whose information will be disclosed? Please print clearly.

Name			Date of Birth
Home Address	City/Town	State	Zip
Telephone			
Email Address			

Would you like us to email you?

Using email involves risks. While security measures are in place, the office sharing information cannot always control these risks. It is possible that emailed information could be read by a third party.

By initialing I give permission to email me, and I accept the risks associated with using email. **INITIAL HERE_____**

Who can we speak to?

I authorize the offices listed above to share information about me with each other and to share my information with the people listed below. We may discuss this information electronically and verbally.

- *Change Health Care*, the company that pays for medications; *Medical Care Development*, the company that issues payment for financial assistance; *Centers for Medicare and Medicaid Services*
- My pharmacy: _____
- My insurance company: _____
- My doctor or health care provider's office: _____
- My case management agency: _____
- My friend or family member: (Optional. Please complete below information.)

Name	Phone	Email

What is the purpose of the disclosure?

☐ Personal request	☑ To coordinate or manage care
☐ For a legal matter, including testimony	☑ To see if I qualify for insurance coverage, insurance, or benefits
☐ Other:	

What information should be released or obtained? Please check all that apply.

General permission:	**Special permission: Drug/Alcohol Treatment or Referral for Services**
☐ All health information from the office(s) checked above ☐ Claims or encounter data (information about visits to health care providers) ☐ Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits ☐ Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2019" or "Claims from 2018-2020") ☑ Other: *Information related to my health, claims, and encounters. Information related to my care.*	☐ Include **all** drug/alcohol information in the release ☐ Include only the **specific** drug/alcohol records checked: ☐ Diagnosis and treatment ☐ Clinical notes and discharge summaries ☐ Drug/Alcohol history or summary ☐ Payment or claims information ☐ Living situation and social supports ☐ Medication, dosages or supplies ☐ Lab results ☐ Other: _____
Special permission: Mental/Behavioral Health Services ☐ Include this information in the release ☐ I want to review my mental health/behavioral health record before release. I understand that the review will be supervised. Maine law allows us to share this information with other health care providers and health plans to coordinate and manage your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.	**Special permission: HIV/AIDS Status/Test Results** ☑ Include this information in the release. Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if it is misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.

I understand and agree that:

- I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.
- My treatment, payment for services, or benefits will not depend on whether I sign this form unless I am requesting or disclosing information to apply for benefits.
- "Information" may be in written, spoken and/or electronic format, and includes information about me from other healthcare providers (such as doctors, hospitals, and counselors) that is included in my files. My signature allows the people/offices named on the reverse to discuss my information for the purposes noted on this form.
- My information will be kept confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, a notice will be included with the records saying the information may not be re-released or shared without my written permission.
- I may revoke (take back) my permission to release my information by filling out the Revocation Form found at http://maine.gov/dhhs/privacy/index.shtml and sending it to the office that shared my information. The Revocation Form is effective only after it is received and does not apply to information that was already shared.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance.
- This form expires **one year** from the date below unless I write an earlier date here: _____
- This form permits additional releases until it expires.

Date: _____ **Signature:** _____

Personal representative's authority to sign: _____