Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Authorization to Release Information

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

❒Office of MaineCare Services	❒ Substance Abuse and Mental Health Services
❒Office for Family Independence including Medical Review Team	❒ Office of Child and Family Services
❒ Maine Centers for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:

Individual's Name:	Individual's Date of Birth: Individual's Social Security Number:

Individual's Address:

Street Town/City State Zip Code

Records to be released, including written, electronic and verbal communication:

❒All Healthcare, including treatment, services, supplies and medicines

❒ Claims Information ❒Billing, payment, income, banking, tax, asset, and/or other information regarding eligibility for DHHS program benefits such as MaineCare

❒Other: _____

❒ Limit to the following date(s) or type(s) of information:
(e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/14 - 1/15/14")

I authorize the DHHS office(s) checked above to: ❒Release my information to: ❒ Obtain my information from:

Name: _____

Address: _____
Street Town/City State Zip Code

Fax No., where applicable: _____ Phone No. to verify Receipt of Fax _____

If requesting that electronic information be transmitted by email, please clearly print the email address below:

_____

❒ I understand that DHHS systems may not be able to send my information securely through email. I understand that email and the internet have risks that DHHS cannot control and that the information possibly could be read by a third party. I accept those risks and still request that DHHS send my information by email. Initials _____

Please allow the office(s) named above to disclose my information for the following purpose(s):

❒ For a legal matter, including an administrative hearing ❒ To see if I qualify for insurance coverage or benefits
❒ For coordination of my care ❒ A Personal Request ❒ Other (note here):

By initialing below, I agree to disclose the following types of records:

_____ **Mental health treatment provider or program**

_____ **Substance/alcohol/drug Abuse treatment provider or program**

_____ **HIV infection status or test results:** Maine law requires us to tell you that releasing this information may have implications. Positive implications may include giving you more complete care, and negative implications may include discrimination if the data is misused. DHHS will protect your HIV data, and all your records, as the law requires.

I (individual/personal representative of individual) permit DHHS to release and/or obtain my records as written on Page 1 of this form. I understand and agree to the following:

- This form will expire one year from the date I sign below, unless I revoke (take back) my permission sooner by completing, signing and sending in the Revocation Form found on the DHHS website at http://www.maine.gov/dhhs/privacy/index.shtml. I may call DHHS at 207-287-3707 and ask for the office where I receive services if I need help revoking this form.
- I understand that taking back my permission to release my information does not apply to the information that was already shared after I signed this form.
- If I take back my permission to release my information, or if I refuse to release some or all of my healthcare or insurance information, that may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- This form permits the people or offices listed on Page 1 to speak to each other for the purpose(s) on this form.
- If I am disclosing healthcare information, I agree that records of other providers (such as doctors, hospitals, and counselors) in my file are included in this release.
- Unless I am applying for benefits, DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form.
- I have the right to make a written request to review my records. If I wish to receive a copy of my healthcare or billing information, a fee may be charged as permitted by law.
- If I want to review my mental health program or provider records before they are released, I must check **THIS BOX**. ❒ I understand that the review will be supervised.
- DHHS offices will keep my information confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program records are included in this release, federal law requires the person sharing those records to include a notice saying that such information may not be re-released or shared without my written permission, unless required or permitted by law.
- I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Date: _____ Signature_____

Personal Representative's authority to sign: _____