State of Maine Workers' Compensation Board
Limited Release of Medical/Health Care Information
Related to HIV/AIDS and Sexually Transmitted Diseases

Name: SSN (last 4 digits): XXX-XX-

Date of Birth: Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms adopted by the State of Maine Workers' Compensation Board for the release of protected medical/health care information. The Board's forms may NOT be altered. Abuses may result in penalties.

Notice to employee: The employer/insurer/employee representative contends your health care providers' medical records related to:

☐ Your HIV infection status, including the results of an HIV test

☐ The diagnosis, treatment and care of sexually transmitted diseases

are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers to release the records they have related to the diagnosis, treatment and care of the condition(s) listed above, regardless of the date of injury. This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes my health care practitioner(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

Voluntary: I undersand I may choose not to complete this form. If I choose not to complete this form, my claim for benefits may be denied.

Limited: I understand this form gives my health care providers permission to release only the medical records related to the condition(s) indicated above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: The information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

Potential Implications of Release: Releasing this information may have implications. Positive implications may include giving you more complete care. Negative implications may include discrimination if the data is misused.

IMPORTANT NOTICE: By signing this form I understand that I am authorizing the release of my medical records related to my HIV infection status and/or my medical records regarding diagnosis, treatment and care of sexually transmitted diseases.

I authorize release of my medical records to: _____
(Name of Recipient)

Address of Recipient:

_____

Format Requested (circle one): **Electronically (if available)**: _____ **Fax to**: _____

Mail to : _____

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature_____ **Date**:_____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).