**Maine Department of Health and Human Services – Authorization for Release of Information**

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

| | |
|---|---|
| ☑ Office of Maine Care Services | ☐ Substance Abuse and Mental Health Services |
| ☐ Office for Family Independence | ☐ Office of Child and Family Services |
| ☐ Maine Centers for Disease Control and Prevention | ☐ Office of Aging and Disability Services |
| ☐ Dorothea Dix Psychiatric Center | ☐ Other: |
| ☐ Riverview Psychiatric Center | |

| | |
|---|---|
| Individual's Name: | Individual's Date of Birth:<br><br>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

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

☐ Limit to the following date(s) or type(s) of information:
(e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/12- 1/15/12")

☐ Claims

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 potentially 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):

☐ Legal ☐ Insurance ☐ Coordination of Care ☐ Personal Request ☐ Other:

By initialing below, I wish for my release to include 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 named above,) give permission to the DHHS office(s) listed above to release and/or share my records as written on this form. This form will remain in effect for one year from the date below. Other releases of my information are permitted during that time unless I revoke this form.

I further understand and agree that:

- DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form, unless I need to sign this form so that the right offices of DHHS can decide if I qualify for benefits.
- I have the right to make a written request to access and copy my healthcare or billing information, and a copy fee will be charged as permitted by law.
- If I want a review of my mental health program or provider records before they are released, I can check here. ☐ I understand that the review will be supervised.
- I may take back my permission to share the records listed on this form at any time by contacting the Privacy Officer of the specific DHHS office at: Beth Glidden DHHS, 11 SHS Augusta, ME 04333 or (207) 624-6913 TTY users: Dial 711
- I understand that taking back my permission does not apply to the information that was already shared with my signature on this form. If I revoke my permission, it may be the basis for denial of health benefits or other insurance coverage.
- I may refuse to disclose all or some health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- 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 confidentiality laws.
- If alcohol or drug provider or program records are included in this release, DHHS will tell the person receiving the records that they may not be shared with others who are not on this form without my written permission, unless required or permitted by law.
- I am signing this form voluntarily and I have a right to a signed copy of this form if I request one.

Date: _____ Signature_____

Personal Representative's authority to sign: _____