OCFS Guide to Using the Authorization to Release Information Form to Obtain Records from Providers Outside of the Department

Below is information to guide you through the process of assisting clients in completing the OCFS Authorization to Release Information Form which was distributed by Central Office in May of 2018. The final version of this form (which should be used until further notice) is labeled "OCFS Authorization Form FINAL". This guide was prepared by the OCFS Privacy Liaison, Brieanna Gutierrez, if you have any questions or concerns related to this release or how to complete it, please email Brie at brieanna.gutierrez@maine.gov.

This release is used to obtain records from outside providers and for individuals outside the Department to make a request for our records. **This guide will walk you through how to assist clients in completing the release in order to obtain information from providers outside of the Department.**

Important Reminder: Please remember that clients must be given the ability to review this release to understand what information will be released. Clients must voluntarily complete and sign this agreement indicating their consent to the release of information.

Section 1 –

Which DHHS office(s) should help you? Please check.

❒Office of MaineCare Services	❒ Substance Abuse and Mental Health Services
❒Office for Family Independence and Medical Review Team **A** -	❒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:

Is the DHHS office releasing information from its records? ❒ **Or obtaining records from a provider?** ❒ - **B**

A. Check the box for "Office of Child and Family Services".
B. Check the box for "Or obtaining records from a provider?"

Section 2 –

Whose information is being released? Please print clearly. **C**

Individual's Name		Date of Birth	Social Security #
Home Address	Town/City	State	Zip Code
Telephone ( ) -	Email address @		

C. Your client's information goes in this section. The client should use his or her full name and correct information so the provider can easily identify whose records they are to release.

Section 3 – More than one box can be checked in this section.

What information should DHHS release or obtain? Please check all that apply.

D **General permission:**

❒**All** health information
❒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, 2017" or "Claims from 2015-2017")

_____

❒Other:_____

E **Special permission: Drug/Alcohol Referral or Services**

❒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: _____

F **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.

Please note: Maine law allows us to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.

G **Special permission: HIV/AIDS Status/Test Results**

❒Include this information in the release

Please note: 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 your data is misused. **DHHS** will protect your HIV data, and all your information, as the law requires.

D. "General Permission" – Check the box that applies to the type of information the Department is seeking from the provider, most often this will be the "All health information" box.

E. "Special Permission: Drug/Alcohol Referral or Services" – Federal law requires that clients specifically consent to the release of information regarding drugs and alcohol (including information regarding substance abuse treatment). This consent is in addition to the box that was checked in Section 3, Part D. Check the box that applies to the type of information the Department is seeking from the provider.

F. "Special Permission: Mental/Behavioral Health Services" – Federal law requires that clients specifically consent to the release of information regarding mental and behavioral health services. This consent is in addition to the box that was checked in Section 3, Part D. Check the box that applies to the type of information the Department is seeking from the provider.

G. "Special Permission: HIV/AIDS Status/Test Results" – If the client's HIV/AIDS status is pertinent to the Department's assessment or case this box should be checked.

Section 4 –

Are you asking DHHS to send or receive your information by EMAIL? ❒ **Yes.** **H**

Although DHHS has privacy and security protections for my information, I understand that email and the internet have risks that DHHS cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask DHHS to send my information by email. **INITIAL HERE** _____ **I**

Where should your information be sent by email? Please print the email address clearly: **J**

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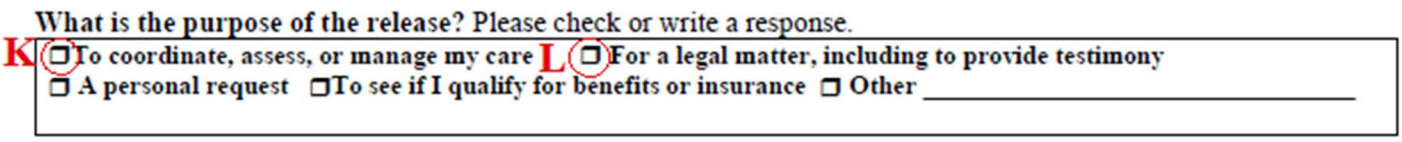
H. Some providers may be able to provide the Department with records electronically. If they are able to do so and you would like to receive the records electronically, check this box. Keep in mind that some records may be too large to send via email. Also, keep in mind whether you need a certified or attested copy of the records, as it may not be possible for the provider to send certified/attested records via email.

I. If you are requesting that records be sent via email, and the client is willing to consent to the records being emailed, the client will need to initial in this space to indicate their consent.

J. If you are requesting that records be sent via email, clearly print the email address of the DHHS employee who should receive the records.

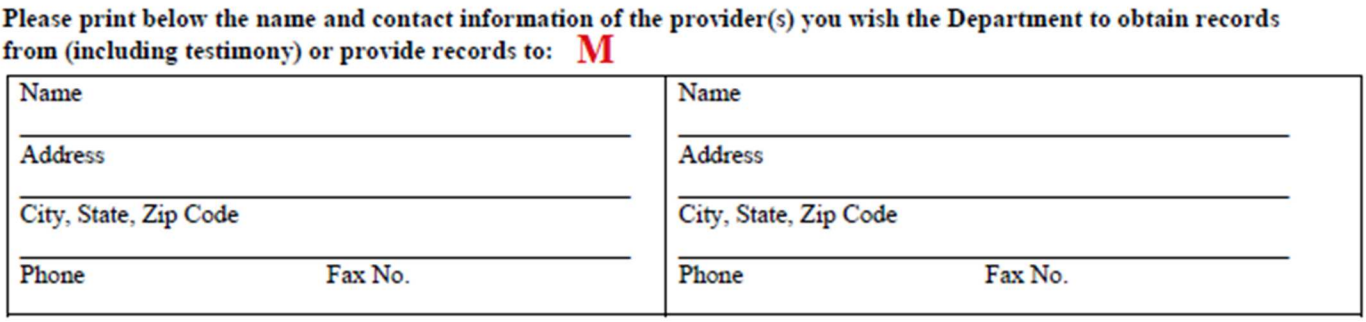
Section 5 – More than one box can be checked in this section.



K. If the purpose of this release is to gather records from the outside provider in connection with assessing child safety, assessing progress in treatment, or other reasons related to an assessment or case, this box should be checked as the reason for the request.

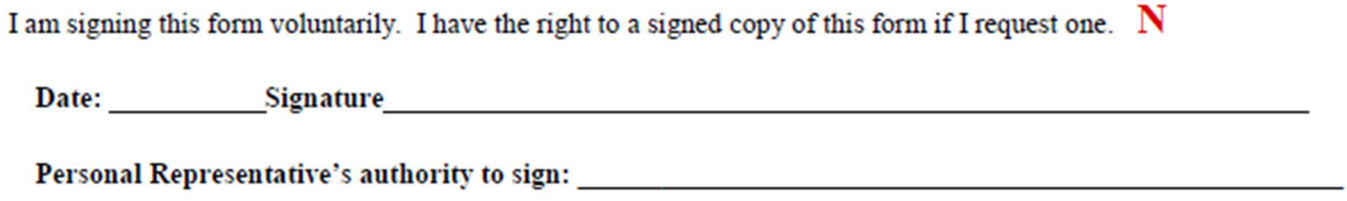
L. This box should be check if it is possible the provider will be asked to testify at a court hearing.

Section 6 –



M. The provider's information should be printed here. Although there are two boxes, a separate release form should be completed for each provider the Department is seeking to obtain information from.

Section 7 -



N. The client will sign and date. If someone is signing this form on behalf of the client (for example, a parent is signing on their child's behalf or a guardian is signing on behalf of an incapacitated adult), they should describe their authority to sign on the "Personal Representative's authority to sign:" line.