



## Authorization to Release Information

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

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

<input type="checkbox"/> Office of MaineCare Services	<input type="checkbox"/> Substance Abuse and Mental Health Services
<input type="checkbox"/> Office for Family Independence and Medical Review Team	<input type="checkbox"/> Office of Child and Family Services
<input type="checkbox"/> Maine Center for Disease Control and Prevention	<input type="checkbox"/> Office of Aging and Disability Services
<input type="checkbox"/> Dorothea Dix Psychiatric Center	<input type="checkbox"/> Office of Administrative Hearings
<input type="checkbox"/> Riverview Psychiatric Center	<input type="checkbox"/> Other: _____

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

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

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

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

<p><b><u>General permission:</u></b></p> <p><input type="checkbox"/> All health information</p> <p><input type="checkbox"/> Claims or encounter data (information about visits to health care providers)</p> <p><input type="checkbox"/> Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits</p> <p><input type="checkbox"/> Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2017" or "Claims from 2015-2017")</p> <p>_____</p> <p><input type="checkbox"/> Other: _____</p>	<p><b><u>Special permission: Drug/Alcohol Referral or Services</u></b></p> <p><input type="checkbox"/> Include <b>all</b> drug/alcohol information in the release</p> <p><input type="checkbox"/> Include only the <b>specific</b> drug/alcohol records checked:</p> <p><input type="checkbox"/> Diagnosis and treatment</p> <p><input type="checkbox"/> Clinical notes and discharge summaries</p> <p><input type="checkbox"/> Drug/Alcohol history or summary</p> <p><input type="checkbox"/> Payment or claims information</p> <p><input type="checkbox"/> Living situation and social supports</p> <p><input type="checkbox"/> Medication, dosages or supplies</p> <p><input type="checkbox"/> Lab results</p> <p><input type="checkbox"/> Other: _____</p>
<p><b><u>Special permission: Mental/Behavioral Health Services</u></b></p> <p><input type="checkbox"/> Include this information in the release</p> <p><input type="checkbox"/> I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.</p> <p><b>Please note:</b> 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.</p>	<p><b><u>Special permission: HIV/AIDS Status/Test Results</u></b></p> <p><input type="checkbox"/> Include this information in the release</p> <p><b>Please note:</b> 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. <b>DHHS</b> will protect your HIV data, and all your information, as the law requires.</p>

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

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. <b>INITIAL HERE</b> _____
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**Where should your information be sent by email? Please print the email address clearly:**

**What is the purpose of the release?** Please check or write a response.

- To coordinate, assess, or manage my care     For a legal matter, including to provide testimony  
 A personal request     To see if I qualify for benefits or insurance     Other \_\_\_\_\_

**Please print below the name and contact information of the provider(s) you wish the Department to obtain records from (including testimony) or provide records to:**

Name _____ Address _____ City, State, Zip Code _____ Phone _____ Fax No. _____	Name _____ Address _____ City, State, Zip Code _____ Phone _____ Fax No. _____
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I understand and agree that:

- “Information” may be in written, spoken and/or electronic format.
- This form will expire **one year** from the date below unless I revoke (take back) my permission sooner.
- To take back my permission, I will fill out the Revocation Form found at <http://www.maine.gov/dhhs/privacy/index.shtml> and send it to the office where I receive services. It will not apply to the information that DHHS already released with my permission.
- 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 coverage.
- I permit the people and/or offices listed on this form to speak to each other for the purpose(s) on this form.
- Health information from other providers (such as doctors, hospitals, and counselors) in my DHHS file is included in this release.
- Unless I am applying for benefits, DHHS will not base my treatment, payment for services, or benefits on whether I sign this form.
- DHHS offices will keep my information 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, DHHS will include a notice saying that such information may not be re-released or shared without my written permission.

I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.

**Date:** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Personal Representative’s authority to sign:** \_\_\_\_\_