



STATE OF MAINE
Department of Public Safety
Maine State Police
Weapons and Professional Licensing



JANET T. MILLS
Governor

164 State House Station
Augusta, Maine
04333-0164

COLONEL JOHN E. COTE
Chief

MICHAEL SAUSCHUCK
Commissioner

LT. COL. WILLIAM S. HARWOOD
Deputy Chief

To: Applicant for Renewal of Professional Investigator License

Subject: Professional Investigator Renewal Application Procedure

Enclosed is a renewal application for a Professional Investigator License and three Authority to Release Information forms.

- Form: P-3 – Professional Investigator - Authority to release information to the Chief for the purpose of evaluating information supplied on the application for an Investigative Assistant license pursuant 32 M.R.S.A. § 8105.
- Form: Authorization to release information for the purpose of applying for a Professional Investigator license pursuant 32 M.R.S.A. § 8105.
- Form: 577 – Client Authorization to Release Information specifically for Dorothea Dix Psychiatric Center or Riverview Psychiatric Center.

You must submit all of the completed forms listed above with the following:

1. Application fee of \$500.00 and State Bureau of Identification record check fee of \$21.00 for a total of \$521.00 payable to Treasurer, State of Maine.

Once the processing of your application materials has been completed, which takes approximately six to eight weeks, you will receive an approval letter requesting a '4 YEAR' continuation certificate from your insurance company. If you have changed your insurance company, please notify us and a new bond form will be provided. You must also submit proof of commercial general liability insurance. You may submit a current photograph with your continuation certificate or call to schedule an appointment to have a photograph taken for your ID card.

If you require further assistance, please contact this office at 624-7210.

NOTE: This application and any supporting documentation are public records pursuant to 1 M.R.S. § 402(3), and, with the exception of portions identified as confidential by statute (e.g., social security numbers; mental health adjudications; college transcripts), may be disseminated in response to a request made pursuant to the Freedom of Access Act.

OFFICES LOCATED AT: 45 COMMERCE DRIVE, SUITE 1

(207) 624-7210 (Voice)

(207) 624-4478 (TDD)

(207) 287-3424 (Fax)



STATE OF MAINE - Department of Health and Human Services (DHHS)

Client Authorization to Release Information Specifically for:
Dorothea Dix Psychiatric Center or Riverview Psychiatric Center
Please Print Legibly or Type

Client's Name _____ DOB _____ SSN _____

I hereby authorize [X] Dorothea Dix Psychiatric Center, PO Box 926, 656 Bangor Street, Bangor, ME 04402

[X] Riverview Psychiatric Center, 250 Arsenal Street, 11 State House Station, Augusta, ME 04332

Table with 2 columns: To: and Client may check [X] either, or both options. Rows include Disclose Information To... and Obtain Information From ...

This Person or Organization: Maine State Police

Mailing Address: Weapons and Profession Licensing, 164 State House Station, Augusta, ME 04333-0164

Fax #: 207-287-3424 _____ Phone number to verify receipt of information: 207-624-7216

Relationship to Client: _____

(Include fax number and phone number ONLY if fax is being used to transmit information)

Information to Be Disclosed and/or Obtained

[X] Check YES or NO for each of the following:

- Alcohol and/or Drug Treatment - (Authorization is required to share ANY information about alcohol/drug treatment, whether spoken or written)
Any reference to or information about alcohol or other drugs
Assessments / Consultations
Treatment Plan / Crisis Plans / Emergency Services
Discharge Summaries
Face Sheet
Gould Assessment(s)
Legal / Financial
Other
Locus Report
Medical and/or Physical History
Outpatient Treatment
Physical Therapy (PT and/or Occupational Therapy (OT)
Physician Orders, including Medical Index
Progress Notes
Psychiatric History, Evaluations, DSM
Psychological and/or Psychosocial History, Reports, Evaluations
Social History (Recent and/or Developmental)

Purpose for Disclosing and/or Obtaining

- Assistance to obtain government benefits
At the request of the Individual
Coordination with family / concerned persons
Other (specify) Professional Investigator's License
Development of Service / Treatment / Crisis Plans
Eligibility determination entitlements, insurance or employment
Ongoing treatment / care management plans

Initials _____

Please INITIAL and CIRCLE Your Response to EACH of the following statements:

_____ I DO _____ I DO NOTauthorize disclosure of information that refers to treatment or diagnosis of alcohol or drug abuse. I understand that it cannot be re-disclosed without my specific consent.

_____ I DO _____ I DO NOTauthorize disclosure of information that refers to treatment or diagnosis of HIV or AIDS. I understand that some individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, insurance, or social / family relations.

_____ I DO _____ I DO NOTwish to review, prior to its release, any information I have authorized for release.

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released. I understand I have the right to revoke this authorization in writing at any time. I understand that I do not need to sign this form to receive services and that I may receive a copy of this authorization if I wish. The benefits, risks, and consequences of releasing or not releasing this information have been explained to me.

Client Signature or Mark

Date

Witness Signature

Date

Guardian/Parent/Legal Representative Signature (specify role)

Date

This authorization is effective until _____ (date not to exceed one [1] year)

Revocation of this Authorization:

Signature or Mark of Person revoking Authorization

Relationship

Date

Witness Signature (if Mark/Stamp above)

Witness Printed Name

Date

Additional Information for Persons/Organizations Receiving either Substance Abuse or Mental Health Information

For Persons/Organizations Receiving Substance Abuse Information:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For Persons/Organizations Receiving Mental Health Information:

This information has been disclosed to you from records protected by State confidentiality laws (34-B M.R.S.A. §1207); Rights of Recipients of Mental Health Services. This information remains confidential and should not be disclosed any further, except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.



AUTHORIZATION TO RELEASE INFORMATION
FOR THE PURPOSE OF APPLYING FOR LICENSURE AS A
PROFESSIONAL INVESTIGATOR OR INVESTIGATIVE ASSISTANT
PURSUANT TO 32 M.R.S.A. § 8101-8121

Please Print Legibly or Type

Name of Applicant _____ DOB _____

Alias and/or Prior Name(s): _____

Pursuant to 32 M.R.S.A § 8105, I authorize the Riverview Psychiatric Center and the Dorothea Dix Psychiatric Center to disclose any record of whether I have been involuntarily committed to the Riverview Psychiatric Center or the Dorothea Dix Psychiatric Center to the designee of the Commissioner of the Department of Public Safety.

Department of Public Safety
Maine State Police
Weapons and Professional Licensing
164 State House Station
Augusta, ME 04333-0164

Fax#: (207) 287-3424
Telephone #: (207) 624-7210

I understand that the information requested is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material prior to its release. I understand I have the right to revoke this authorization in writing at any time by contacting the licensing authority identified above. I understand that my refusal to sign this release will cause my application for licensure as a contract security company to be rejected. I understand that if the licensing authority receives an affirmative response to its inquiry, I may be asked to authorize the release of additional information to determine my eligibility for licensure as a Private Investigator or Investigative Assistant.

NOTE: This application is a public record pursuant to 1 M.R.S. § 402(3), and, with the exception of portions identified as confidential by statute (e.g., social security numbers; mental health adjudications), may be disseminated publicly.

This authorization is effective for ninety (90) days following my dated signature.

Applicant Signature _____
Date

Witness Signature _____
Date

APPLICANT: RETURN THIS FORM TO THE MAINE STATE POLICE, SPECIAL INVESTIGATIONS UNIT, WITH YOUR LICENSE APPLICATION. RETAIN A COPY FOR YOUR RECORDS.

MAINE STATE POLICE: Send completed form (or a copy) by regular mail with a stamped, self-addressed envelope; OR by fax; OR by e-mail (scan this waiver if using e-mail) to:

Riverview Psychiatric Center, PO Box 724, Augusta ME 04333-0724, Attention Medical Records (fax: 207-287-7127)
and
Dorothea Dix Psychiatric Center, PO Box 926, Bangor ME 04401, Attention Medical Records (fax 207-941-4029)

08/15; 08/20 All previous versions of this form are obsolete.



Authority, pursuant to 32 M.R.S. § 8105, to release information to the Chief of the Maine State Police or his/her designee for the purpose of evaluating information supplied on the application for a Professional Investigator License.

To all law enforcement agencies and courts, either within or outside the State of Maine:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, a copy thereof, within six months of the date appearing below, any information in your possession or control concerning me pertaining to the following:

1. conviction data;
2. any criminal matter in which a formal charging instrument is now pending;
3. adjudication data within the past 5 years relating to any civil violation;
4. fugitive from justice status;
5. incidents of abuse of family or household members within the past 5 years;
6. unlawful use of, or addiction to, marijuana or any other drug;
7. reckless or negligent conduct within the past 5 years.

To all military forces, both State and Federal:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, or a copy thereof, within 6 months of the date appearing below, any information in your possession or control concerning me pertaining to a dishonorable discharge from the military forces.

To the Justice Department, Immigration and Naturalization Service:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, or a copy thereof, within 6 months of the date appearing below, any information in your possession or control concerning me pertaining to being an illegal alien.

To all hospitals and mental institutions wither within or outside the State of Maine:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, or a copy thereof, within 6 months of the date appearing below any information, if contained within your records, pertaining to being adjudged to be mentally defective or committed to a mental institution within the past 5 years.

(Check appropriate box below)

I wish to review this material prior to its release:

I do not wish to review this material prior to its release:

To all above addressed governmental entities:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, or a copy thereof, within 6 months of the date appearing below any information to your possession or control concerning me pertaining to the following:

1. my full name;
2. my full current address and addresses for the prior 5 years;
3. the date and place of my birth any my physical description;
4. my signature

Should there be any questions as to the validity of this release, you may contact me at the address and/or telephone number listed below.

Full Name (Last, First, Middle)(Please Print)		Date of birth	
Complete Physical Address		Telephone #	
City or Town	State	Zip Code	
Complete Mailing Address			
City or Town	State	Zip Code	
Signature of Applicant		Date	
Signature of Witness		Date	

NOTE: This application is a public record pursuant to 1 M.R.S. § 402(3), and, with the exception of portions identified as confidential by statute (e.g., social security numbers; mental health adjudications), may be disseminated publicly.