STATE OF MAINE
BOARD OF OSTEOPATHIC LICENSURE
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AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS

I, _____ of _____

hereby authorize _____ to release, disclose, and furnish **all individually identifiable medical and health care information,** regarding the following patient, including but not limited to any and all medical/treatment records created by other providers in your possession or the possession of your medical practice, to the **Maine Board of Osteopathic Licensure, its agents and/or its attorney (hereafter: Board):**

Patient Name: _____ Patient Date of Birth: _____

By checking below, I also authorize the release of the following portions of health care records/information:

____Mental health treatment records
(Not including psychotherapy notes)

____HIV or AIDS related records

____ Alcohol or Drug Abuse records

____Other _____
Specify

IMPORTANT: If I have authorized the disclosure of **mental health treatment records/information,** I understand and agree that I will not be able to review the records/information before release.

NOTICE: (applicable only if **substance misuse** records are disclosed) The information disclosed includes records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit recipients of such records 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.

Term of Authorization: Except as provided hereinafter, this authorization shall be effective from the date I have signed it until _____. [Cannot exceed 30 months]

Refusal to Sign Release: I understand that I may refuse authorization to disclose all or some health care information. I understand that, if I refuse authorization to disclose all or some health care information to the Board, it may impair the Board's ability to investigate the complaint and to pursue disciplinary action against a license, and that the complaint may be dismissed. I also understand that no treatment will be conditioned upon my signing this authorization, and that my refusal to sign this authorization cannot constitute grounds to deny treatment.

Revoking the Authorization: I have been advised I may revoke this authorization by contacting **the provider** _____, in writing, to request that this authorization be cancelled. If I revoke this authorization, the revocation will not apply to records/information released to the Board before I notified the hospital/record keeper in writing of my change of mind. I understand that my decision to revoke this authorization may impair the Board's ability to investigate the complaint and to pursue disciplinary action against a licensee, and that the complaint may be dismissed.

Purpose of Authorization: I understand the Board of Osteopathic Licensure issues licenses to practice medicine in the State of Maine. I understand that the Board investigates complaints or reports regarding licensed physicians and physician assistants in order to determine whether disciplinary action is needed in order to protect patients and the public interest. I understand that the information I am providing through this authorization will be used solely in connection with the pending investigation of a complaint or report against a licensee and any subsequent disciplinary proceedings.

Re-Disclosure: I understand that the information used and disclosed in accordance with this authorization may be subject to re-disclosure by the Board of Osteopathic Licensure as described above and may no longer be protected by the federal privacy rule. For example, the Board may disclose these records/this information to the licensee, his or her attorney or a consultant hired by the Board or the licensee. However, I also understand that all individually identifiable health records/information provided to the Board of Osteopathic Licensure pursuant to this authorization shall be considered confidential under Maine state law and shall not be used by the Board for any purpose other than that described above without my express written authorization, unless allowed by law.

The Board may also disclose these records/this information to the complainant if I am not that person unless I _____ initial here that I **do not** wish that the records/information be shared with the complainant.

Copy of Authorization: I acknowledge that I have retained a signed copy of this authorization. I agree that this authorization is as valid whether in the original, a photocopy, a facsimile, or in electronic form.

Date: _____ Signature: _____

*Of Individual, or **authorized representative****

PRINTED Name: _____

Relationship to individual: _____

***If you are signing on behalf of the individual, please state your relationship to the individual on the line above, and attach a copy of the order or document that authorizes you to sign and authorize release of the patient's records.**