State of Maine Workers' Compensation Board
Limited Release of Medical/Health Care Information Related to Substance Abuse

Name: SSN (last 4 digits): XXX-XX-

Date of Birth: Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms adopted by the State of Maine Workers' Compensation Board for the release of protected medical/health care information. The Board's forms may NOT be altered. Abuses may result in penalties.

Notice to employee: The employer/insurer/employee representative contends your health care providers' records related to the identity, diagnosis, prognosis, or treatment of substance abuse, regardless of the date of injury, are relevant to whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers, including Part 2 Program(s)_____ to
(name of facility/provider)
release the records they have related to the identity, diagnosis, prognosis, or treatment of substance abuse. This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes my health care provider(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

Voluntary: I understand I may choose not to complete this form. If I choose not to complete this form, my claim for benefits may be denied.

Limited: I understand this form gives my health care providers permission to release only those health records related to the condition(s) listed above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: The information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

I authorize release of my medical records to: _____
(Name of Recipient)

Address of Recipient:

_____

Format Requested (circle one): **Electronically (if available)**: _____ **Fax to**: _____

Mail to : _____

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature_____ **Date**:_____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).