



State of Maine Workers' Compensation Board Revocation of Limited Release of Medical/Health Care Information

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

Date of Birth: _____ Date of Injury/Illness: _____

Notice to employee: This revocation must be sent to the recipient who requested access to your records. You should keep a copy of the signed form for your records.

I _____ am revoking the limited release of medical/health care information
(Name)

signed by me on _____ and provided to _____. This release revokes authorization
(Date) (Employer/Insurer)

for all health care providers, unless specified below:

Only the following health care providers: _____

I understand this revocation may result in a loss of or reduction in entitlement to workers' compensation benefits. I also understand this release does not apply to medical records already provided pursuant to the release.

I have read and understood this form.

I hereby revoke the release of my medical records:

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

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

Notice to employer/insurer/employee representative: Within 14 days after receipt of this form you must forward a copy to all health care providers to whom you provided the limited release signed by the employee on the date listed above.

Notice to employee: Your health care provider may not receive your revocation immediately and will continue to release your records until they receive a copy of this revocation. You should provide a copy of this revocation to your health care providers as soon as possible. You should also keep a copy of this revocation for your records.