Department of

Authorization to Release Information

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

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

which office(s) should help you? Please C	neck.		
□Office of MaineCare Services		☐ Office of Behavioral Health	
Office for Family Independence and Medical Review Team		☐ Office of Child and Family Services	
☐ Maine Center for Disease Control and Prevention		☐ Office of Aging and Disability Services	
☐ Dorothea Dix Psychiatric Center		☐ Office of Administrative Hearings	
☐ Riverview Psychiatric Center		☐ Other:	
☐ Division of Licensing and Certification		☐ Other:	
Whose information will be disclosed? Ple	ase print clearly.		
Individual's Name		Date of Birth	
Home Address	Town/City	State	Zip Code
Telephone	Email address of individual/personal representative (optional)		
Name of Individual		Organization	
Address	Town/City	State	Zip Code
Telephone	Email address (optional)		
What is the purpose of the disclosure?			
☐Personal request	☐To coordinate or manage my care		
☐For a legal matter, including testimony	☐To see whether I qualify for insurance coverage, services, or benefits		
□Other:	<u> </u>		,
Γο share the information with others by I	EMAIL, please initial a	and complete the follo	wing.
I understand that email and the internet have	risks that the office sharing	ng my information cann	ot control. It is possible
that my emailed information could be read by information by email. INITIALHERE	a third party. I ACCEPT	•	•
Please print the email address where yo		tion sent:	

What information should be released or obtained? Please check all that apply.

Ger	eral permission:	Special permission: Drug/Alcohol Treatment or Referral for Services
	All health information from the office(s) checked above	☐ Include all drug/alcohol information in the release
	Claims or encounter data (information about visits to health care providers)	Include only the specific drug/alcohol records checked:
	Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2019" or "Claims from 2018-2020") Other:	 □ Diagnosis and treatment □ Clinical notes and discharge summaries □ Drug/Alcohol history or summary □ Payment or claims information □ Living situation and social supports □ Medication, dosages or supplies □ Lab results □ Other:
Sne	cial permission: Mental/Behavioral Health Services	Special permission: HIV/AIDS Status/Test Results
	Include this information in the release	☐ Include this information in the release
	I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.	Please note: 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 it is
with	ase note: Maine law allows us to share this information of other health care providers and health plans to redinate and manage your care (to help take care of you) ong as we make a reasonable effort to notify you of the ase.	misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.
I und	I am signing this form voluntarily. I have the right to a s My treatment, payment for services, or benefits will not disclosing information to apply for benefits.	signed copy of this form if I request one. t depend on whether I sign this form unless I am requesting or
•	"Information" may be in written, spoken and/or electron healthcare providers (such as doctors, hospitals, and cou people/offices named on the reverse to discuss my infor	ic format, and includes information about me from other unselors) that is included in my files. My signature allows the mation for the purposes noted on this form. I 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.
•		disorder) records are included in this release, a notice will be may not be re-released or shared without my written permission
•	I may revoke (take back) my permission to release my in http://www.maine.gov/dhhs/privacy/index.shtml and se Revocation Form is effective only after it is received and	nding it to the office that shared my information. The
•	•	or all of my information, my choice could lead to an improper
•	This form expires one year from the date below unless This form permits additional releases until it expires.	I write an earlier date here:
	unis form permits additional releases until it expires	
•	This form permits additional releases than it expires.	