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.

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☐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.

General 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 ☐ Include only the specific drug/alcohol records checked:			
	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	Diagnosis and treatment			
	needed to see if you qualify for DHHS program	Clinical notes and discharge summaries			
	benefits	Drug/Alcohol history or summaryPayment or claims information			
	Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2019" or "Claims	Living situation and social supports			
	from 2018-2020")	☐ Medication, dosages or supplies			
	Other: Housing Subsidy Benefit Information i.e. Household Composition,	☐ Lab results			
	Occupancy, Housing Assistance Payment, Payee Information and Subsidy Paid	□ Other:			
Spe	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 rdinate 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	lerstand and agree that: 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.	depend on whether I sign this form unless I am requesting or			
•	"Information" may be in written, spoken and/or electroni healthcare providers (such as doctors, hospitals, and cou people/offices named on the reverse to discuss my infor-	inselors) that is included in my files. My signature allows the			
•	My information will be kept confidential as required by not required by law to keep it private, it may no longer by	law. If I choose to share my information with others who are be protected by federal confidentiality laws.			
•		lisorder) records are included in this release, a notice will be nay not be re-released or shared without my written permissio			
•	I may revoke (take back) my permission to release my int http://www.maine.gov/dhhs/privacy/index.shtml and ser Revocation Form is effective only after it is received and	nding it to the office that shared my information. The			
•	If I take back my permission or refuse to release some o diagnosis or treatment, or denial of insurance.	r all of my information, my choice could lead to an improper			
•	This form expires one year from the date below unless l	write an earlier date here:			
•	This form permits additional releases until it expires.				
Date	: Signature:				
Perso	Personal Representative's authority to sign:				