Authorization to Release Information

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

☐ Office of MaineCare Services	☐ Substance Abuse and Mental Health Services
☐ Office for Family Independence / Medical Review Team	☐ Office of Child and Family Services
☐ Maine Centers for Disease Control and Prevention	☐ Office of Aging and Disability Services
☐ Dorothea Dix Psychiatric Center	☐ Office of Administrative Hearings
☐ Riverview Psychiatric Center	☐ Other: Alpha One (SCA)
☐ Other: Assessing Services Agency (ASA)	☐ Other: EIM (SCA)
☐ Other:	☐ Other: Catholic Charities (SCA)

Individual's Name:_____Individual's Date of Birth: _____
Individual's Address:
Street: _____

Town/City:_____State:_____Zip Code: _____

I authorize the DHHS offices and/ or other agencies checked above to:
☐**Release my information to:** ☐**a Obtain my information from:** ☐ **Discuss my information with:**

☐Adult Day Services	☐Home Health Agencies	☐Nursing Facilities	☐ Transportation Agencies
☐ Area Agencies on Aging	☐ Hospital(s)	☐ Personal Care Provider(s)	☐ Vocation Rehabilitation
☐ Alzheimer's Respite Program	☐ ICFs	☐ Physician(s)	☐Waiver Services Provider
☐Assessing Services Agency(s)	☐Long Term Care Ombudsman	☐Residential Care Facilities	☐Other_____
☐Case Management Agencies	☐ Neurorehabilitation Clinics	☐ Service Coordination Agency(s)	☐ Other _____

☐Homemaker ☐Neurorehabilitation ☐ Social Security Administration ☐ Other _____

EMAIL: If requesting that electronic information be transmitted by email, please clearly print the email address below:

_____

I understand that the agencies above may not be able to send my information securely through email. I understand that email and the internet have risks that cannot be controlled and that the information possibly could be read by a third party. I accept those risks and still request that my information be sent by email. Initials_____

PURPOSE: The office(s) or agencies named above may disclose or share my information for the following purpose(s):

☐ For a legal matter, including an administrative hearing ☐ A personal request

☐ To see if I qualify for insurance coverage or benefits ☐ Other (note here):_____

☐ To coordinate my care and/or benefits

General permission:	**Special permission**: D**rug/Alcohol Referral or Services**
☐**All** health information from the DHHS office(s) checked above ☐Claims or encounter data (information about visits to health care providers) ☐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, 2017" or "Claims from 2015-2017") _____ ☐Other:_____	☐Include **all** drug/alcohol information in the release ☐Include only the **specific** drug/alcohol records checked: ❒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: _____
Special permission: Mental/Behavioral Health Services ☐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 allows us to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.	**Special permission: HIV/AIDS Status/Test Results** ☐Include this information in the release **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 your data is misused. **DHHS** will protect your HIV data, and all your information, as the law requires.

I (individual/personal representative of individual) permit the office(s) or agencies checked on this form to release and/or obtain my records as written on Page 1 of this form. I understand and agree to the following:

- This form will expire one year from the date I sign below, unless I revoke (take back) my permission sooner. To take back my permission from DHHS, I will complete, sign and send in the Revocation Form found on the DHHS website at http://www.maine.gov/dhhs/privacy/index.shtml to the office that provides me with services. To take back my permission from a non-DHHS agency, I will call that agency directly. I may call DHHS-OADS at 207-287-9200 and ask for the Privacy Liaison in the office that provides me with services if I need help revoking this form.

- I understand that taking back my permission to release my information does not apply to the information that was already shared after I signed this form.

- I agree that additional sharing of my information may occur until this form expires or I take back my permission.

- If I take back my permission to release information, or if I refuse to release some or all of my healthcare or insurance information, that may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.

- This form permits the people or offices checked on Page 1 to speak to each other for the purpose(s) on this form.

- If I am disclosing healthcare information, I agree that records of other providers (such as doctors, hospitals, and counselors) in my file are included in this release.

- Unless I am applying for benefits, DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form.

- I have the right to make a written request to review my records. If I wish to receive a copy of my healthcare or billing information, a fee may be charged as permitted by law.

- If I want to review my mental health program or provider records before they are released, I must check **THIS BOX** ☐. I understand that the review will be supervised.

- My information will be kept confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by federal confidentiality laws.

- If alcohol or drug treatment or program records are included in this release, federal law requires the person sharing those records to include a notice saying that such information may not be re-released or shared without my written permission, unless required or permitted by law.

- I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Date:_____ Signature_____

Personal Representative's authority to sign:_____