



Authorization to Release Information

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

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

<input type="checkbox"/> Office of MaineCare Services	<input type="checkbox"/> Substance Abuse and Mental Health Services
<input type="checkbox"/> Office for Family Independence and Medical Review Team	<input type="checkbox"/> Office of Child and Family Services
<input type="checkbox"/> Maine Center for Disease Control and Prevention	<input type="checkbox"/> Office of Aging and Disability Services
<input type="checkbox"/> Dorothea Dix Psychiatric Center	<input type="checkbox"/> Office of Administrative Hearings
<input type="checkbox"/> Riverview Psychiatric Center	<input type="checkbox"/> Other:

Whose information is being released? Please print clearly.

Individual's Name	Date of Birth	Social Security #
Home Address	Town/City	State Zip Code
Telephone () -	Email address	@

What information should DHHS release? Please check all that apply.

<p>General permission:</p> <p><input type="checkbox"/> All health information from the DHHS office(s) checked above</p> <p><input type="checkbox"/> Claims or encounter data (information about visits to health care providers)</p> <p><input type="checkbox"/> Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits</p> <p><input type="checkbox"/> Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2017" or "Claims from 2015-2017")</p> <p>_____</p> <p><input type="checkbox"/> Other: _____</p>	<p>Special permission: Drug/Alcohol Referral or Services</p> <p><input type="checkbox"/> Include all drug/alcohol information in the release</p> <p><input type="checkbox"/> Include only the specific drug/alcohol records checked:</p> <p><input type="checkbox"/> Diagnosis and treatment</p> <p><input type="checkbox"/> Clinical notes and discharge summaries</p> <p><input type="checkbox"/> Drug/Alcohol history or summary</p> <p><input type="checkbox"/> Payment or claims information</p> <p><input type="checkbox"/> Living situation and social supports</p> <p><input type="checkbox"/> Medication, dosages or supplies</p> <p><input type="checkbox"/> Lab results</p> <p><input type="checkbox"/> Other: _____</p>
<p>Special permission: Mental/Behavioral Health Services</p> <p><input type="checkbox"/> Include this information in the release</p> <p><input type="checkbox"/> I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.</p> <p>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.</p>	<p>Special permission: HIV/AIDS Status/Test Results</p> <p><input type="checkbox"/> Include this information in the release</p> <p>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.</p>

Are you asking DHHS to send your information by EMAIL? Yes.

Although DHHS has privacy and security protections for my information, I understand that email and the internet have risks that DHHS cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask DHHS to send my information by email. INITIAL HERE _____

Where should DHHS send your information by email? Please print the email address clearly:

What is the purpose of the release? Please check or write a response.

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- | |
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| <input type="checkbox"/> To coordinate or manage my care <input type="checkbox"/> For a legal matter, including to provide testimony
<input type="checkbox"/> A personal request <input type="checkbox"/> To see if I qualify for benefits or insurance <input type="checkbox"/> Other _____ |
|---|

Please check and print clearly below: Send my information to Get my information from:

Name Wabanaki Case Management Division of Cornerstone Behavioral Healthcare	Name Wabanaki Case Management Division of Cornerstone Behavioral Healthcare
Address PO Box 1356	Address PO Box 1356
City, State, Zip Code Bangor ME 04402-1356	City, State, Zip Code Bangor ME 04402-1356
Phone (207)992-0411	Fax No.
Fax No.	Phone (207)992-0411

I understand and agree that:

- “Information” may be in written, spoken and/or electronic format.
- This form will expire **one year** from the date below unless I revoke (take back) my permission sooner.
- To take back my permission, I will fill out the Revocation Form found at <http://www.maine.gov/dhhs/privacy/index.shtml> and send it to the office where I receive services. It will not apply to the information that DHHS already released with my permission.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance coverage.
- I permit the people and/or offices listed on this form to speak to each other for the purpose(s) on this form.
- Health information from other providers (such as doctors, hospitals, and counselors) in my DHHS file is included in this release.
- Unless I am applying for benefits, DHHS will not base my treatment, payment for services, or benefits on whether I sign this form.
- DHHS offices will keep my information confidential as required by 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.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, DHHS will include a notice saying that such information may not be re-released or shared without my written permission.

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

Date: _____ Signature _____

Personal Representative’s authority to sign: _____