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**.**

❒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: Acentra Health
❒ Division of Licensing and Certification	❒ Other:

Whose information will be disclosed? Please print clearly.

Individual's Name John Doe			Date of Birth 01/01/1980
Home Address 123 Main St.	Town/City Anywhere	State ME	Zip Code 00000
Telephone 207-555-5555	Email address of individual/personal representative (optional)		

Please check: ☒ **Release/Send my information to:** ☒ **Obtain/Get my information from:**

Name of Individual			Organization Acentra Health
Address 82 Running Hill Rd. Suite 202	Town/City South Portland, ME	State	Zip Code 04106
Telephone 866-521-0027	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:	

To share the information with others by EMAIL, please initial and complete the following.

I understand that email and the internet have risks that the office sharing my information cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask to send my information by email**. INITIAL HERE** JD
Please print the email address where you want your information 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 ❒ 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, 2019" or "Claims from 2018-2020") ❒ 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 and manage 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 it is misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.

I understand and agree that:

- I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.
- My treatment, payment for services, or benefits will not depend on whether I sign this form unless I am requesting or disclosing information to apply for benefits.
- "Information" may be in written, spoken and/or electronic format, and includes information about me from other healthcare providers (such as doctors, hospitals, and counselors) that is included in my files. My signature allows the people/offices named on the reverse to discuss my information for the purposes noted on this form.
- My information will be kept 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, a notice will be included with the records saying that such information may not be re-released or shared without my written permission.
- I may revoke (take back) my permission to release my information by filling out the Revocation Form found at http://www.maine.gov/dhhs/privacy/index.shtml and sending it to the office that shared my information. The Revocation Form is effective only after it is received and does not apply to information that was already shared.
- 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.
- This form expires **one year** from the date below unless I write an earlier date here: _____
- This form permits additional releases until it expires.

Date: _____ **Signature:** _____

Personal Representative's authority to sign: _____

Only sign if you are the member's legal guardian or medical power of attorney.