Maine Department of Health and Human Services – Authorization for Release of Information

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

Office of Maine Care Services	☐ Substance Abuse and Mental He	olth Comices	
Office for Family Independence	☐ Office of Child and Family Servi		
☐ Maine Centers for Disease Control and Prevention	☐ Office of Aging and Disability S	ervices	
☐ Dorothea Dix Psychiatric Center	Other:	ci vices	
☐ Riverview Psychiatric Center	2 oner.		
Individual's Name:	Individual's Date of Birth:		
	Individual's Social Security 1	Number:	
Individual's Address:			
Street	Town/City S	State Zip Code	
Records to be released, including written, electronic and verbal	communication:		
All Healthcare, including treatment, services, supplies and medicines			
Billing, payment, income, banking, tax, asset, and/or other information regarding financial eligibility for DHHS program benefits such as MaineCare			
☐ Limit to the following date(s) or type(s) of information: (e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/12- 1/15/12")			
	12-1/13/12)		
I authorize the DHHS office(s) checked above to:		n my information from:	
		n my information from:	
I authorize the DHHS office(s) checked above to: Relea Name: Carlin & Shapiro, P.A. Address: 178 Middle Street, Ste. 401	se my information to:	n my information from: 04101	
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I authorize the DHHS office(s) checked above to: Relea Name: Carlin & Shapiro, P.A. Address: 178 Middle Street, Ste. 401 Street	se my information to:	04101 Zip Code	
I authorize the DHHS office(s) checked above to: Relea Name: Carlin & Shapiro, P.A. Address: 178 Middle Street, Ste. 401 Street	Portland ME Town/City State No. to verify Receipt of Fax	04101 Zip Code 207-775-2882	
I authorize the DHHS office(s) checked above to: Relea Name: Carlin & Shapiro, P.A. Address: 178 Middle Street, Ste. 401 Street Fax No., where applicable: 207-775-2727 Phone If requesting that electronic information be transmitted by email	se my information to:	04101 Zip Code 207-775-2882	
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By initialing	below, I wish for my release to include the following types of records:	
Me	ntal health treatment provider or program	
Sul	ostance/Alcohol/drug abuse treatment provider or program	
HIV infection status or test results: Maine law requires us to tell you that releasing this information may have implications. Positive implications may include giving you more complete care, and negative implications may include discrimination if the data is misused. DHHS will protect your HIV data, and all your records, as the law requires.		
release and/or	ersonal representative of individual named above,) give permission to the DHHS office(s) listed above t share my records as written on this form. This form will remain in effect for one year from the date below of my information are permitted during that time unless I revoke this form.	
I furthe	r understand and agree that:	
•	DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form, unless I need to sign this form so that the right offices of DHHS can decide if I qualify for benefits.	
•	I have the right to make a written request to access and copy my healthcare or billing information, and a copy fee will be charged as permitted by law.	
•	If I want a review of my mental health program or provider records before they are released, I can check here. I understand that the review will be supervised.	
•	I may take back my permission to share the records listed on this form at any time by contacting the Privacy Officer of the specific DHHS office at:	
٠	I understand that taking back my permission does not apply to the information that was already shared with my signature on this form. If I revoke my permission, it may be the basis for denial of health benefits or other insurance coverage.	
٠	I may refuse to disclose all or some health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.	
٠	DHHS offices will keep my information 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 confidentiality laws.	
•	If alcohol or drug provider or program records are included in this release, DHHS will tell the person receiving the records that they may not be shared with others who are not on this form without my written permission, unless required or permitted by law.	
•	I am signing this form voluntarily and I have a right to a signed copy of this form if I request one.	
Date:	Signature	