

By initialing below, I wish for my release to include the following types of records:

_____ **Mental health treatment provider or program**

_____ **Substance/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.

I (individual/personal representative of individual named above,) give permission to the DHHS office(s) listed above to release and/or share my records as written on this form. This form will remain in effect for one year from the date below. Other releases of my information are permitted during that time unless I revoke this form.

I further 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:

- 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.
- 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.
- 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 _____

Personal Representative's authority to sign: _____