Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Ricker Hamilton, Commissioner

Authorization to Release Information

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

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

☑Office of MaineCare Services	❒ Substance Abuse and Mental Health Services
☑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:

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.

General permission: ☑**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:_____	**Special permission**: D**rug/Alcohol Referral or Services** ❒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.

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: bcarlin@elderlawinme.com; pshapiro@elderlawinme.com; ltownsend@elderlawinme.com

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

☑ **To coordinate or manage my care** ☑ **For a legal matter, including to provide testimony**
❒ **A personal request** ☑ **To see if I qualify for benefits or insurance** ❒ **Other** _____

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

Name Carlin & Shapiro, P.A.	Name Barbara Carlin, Esq.; Paul Shapiro, Esq.; Lynn Townsend, Esq.
Address 48 Free Street, Suite 260	Address 48 Free Street, Suite 260
City, State, Zip Code Portland, ME 04101	City, State, Zip Code Portland, ME 04101
Phone 207-775-2882 Fax No. 207-775-2727	Phone 207-775-2882 Fax No. 207-775-2727

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: _____