UNIVERSITY OF MAINE SYSTEM
AUTHORIZATION for the Use and/or Disclosure
of HEALTH INFORMATION
(Not to be used for Psychotherapy Notes)

Name:_____ Address: _____

Telephone: _____ Student/Empl. ID #_____ DOB: _____

Instructions: Please complete all of the sections of this form. Please note incomplete or inaccurately completed forms will not be honored.

I hereby authorize the University of Maine System to use and/or disclose my health information as described below. List the type and amount of information to be used or disclosed, and dates of service if applicable: _____

I understand that my specific consent is required to use and/or disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. Please fill out all of the sections even if one or more of them are not applicable to you. Any of the following sections not completed will be presumed to be a refusal to authorize use and/or disclosure of such information. (The information below will not be FAXED even if disclosure is authorized.)

(A) HIV status information. I DO/DO NOT (Circle one) authorize use and/or disclosure of health information related to testing, diagnosis or treatment of HIV, ARC or AIDS.

(B) Substance Abuse Treatment Information. I DO/DO NOT (Circle one) authorize use and/or disclosure of health information related to treatment, testing or diagnosis of alcohol or substance abuse. Substance abuse treatment information may not be re-disclosed without the Individual's express written authorization or as otherwise permitted by law. Unless otherwise revoked, this SPECIFIC authorization will expire on _____, 20___ or 6 months from the date of signing whichever comes first.

(C) Mental Health Treatment Information. I DO/DO NOT (Circle one) authorize use and/or disclosure of health information related to mental health treatment, not including "Psychotherapy Notes" which cannot be disclosed pursuant to this Authorization.

The Purpose of Use and/or Disclosure is: _____
Release Information to: (Name of Individual or Facility): _____
Address: _____

Subsequent Disclosures: I DO /DO NOT (Circle one) authorize subsequent disclosures to be made of the health information identified above. This does not apply to re-disclosure of alcohol or substance abuse treatment information disclosed under section (B) above.

* I understand I have the right to revoke this authorization at any time by sending a written revocation to_____. I understand the revocation will not apply to information that has already been released in response to this authorization and may be the basis for the denial of health benefits or other insurance coverage or benefits.
* Unless otherwise revoked, this authorization will expire on _____, 20__, or 30 months from the date of signing whichever comes first.
* I understand that authorizing the use or disclosure of this health information is voluntary.
* Partial or incomplete disclosures, as compared to the information requested to be disclosed, will be labeled as such.

* I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable), except (a) if my treatment is related to research, then an authorization may be required; or (b) if the purpose of the health care is solely to create health information to

be provided to a third party, then an authorization may be required.

* I may refuse to disclose all or some health information, but that refusal may result in improper diagnosis or treatment, denial of coverage or claim for health benefits or other insurance or other adverse consequences.

* I understand that I have a right to a copy of this authorization.

* I understand any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules anymore.

* If I have questions about use or disclosure of my health information, I may contact _____
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Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____
(if under 18 years of age)

Personal Representative: _____ Date: _____

IF NOT SIGNED BY THE INDIVIDUAL, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Relationship to the Individual: _____

Describe Authority to Act for Individual: _____

RE-DISCLOSURE OF MEDICAL RECORD INFORMATION IS STRICTLY FORBIDDEN BY RECIPIENTS UNLESS DULY AUTHORIZED BY THE PATIENT.

ADDITIONAL NOTICE TO RECIPIENTS OF SUBSTANCE ABUSE TREATMENT INFORMATION:
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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