AUTHORIZATION For the Use and/or DISCLOSURE of PROTECTED HEALTH INFORMATION
University Services
65 Texas Avenue, Bangor, Maine 04401
Telephone: 207-262-7937

Name:____ **Address:**____

Telephone:__________________________ **EMPL ID#**_________________________ **DOB:**_____________________

Instructions: Both State and Federal Law require all of the following sections of this form to be completed. Please note incomplete or inaccurately completed forms will not be honored by the Chancellor's Office/System Wide Services.

I hereby authorize the use or disclosure of my health information by ______________________________________**(Entity Name or Person) as described below:** (List the type and amount of information to be used or disclosed)
____

Purpose of Use/Disclosure____

Chancellor's Office/System Wide Services will only disclose information that it has generated unless additional information is specifically requested. Use "other" line below for this request.

Dates of Service:______________________________**Other:**____

Release Information to: (Name or Facility)____

Address: ____

City/State/Zip: ____

I understand that my specific consent is required to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. I hereby authorize the following to be released:

INITIAL NEXT TO THE RECORDS YOU WISH TO HAVE RELEASED. (*The information below will not be FAXED even if initialed*)

_______mental/emotional health information including reference to antidepressant medications (34-B MRSA Sec. 1207)

_______sexually transmitted disease including STD tests (includes documented history of STD's)

_______positive TB test _______ abortion _______sexual abuse/rape _______sexual preference

_______drug/alcohol abuse: this information is protected by Federal Law (42 U.S.C.-290dd-2)) Information related to treatment, testing or diagnosis of alcohol or substance abuse may not be re-disclosed without the Individual's express written authorization or a court order.

_______HIV/AIDS: this information is protected by Maine's HIV Law (5 MRSA, Part 23, Chapter 501)

I understand I have the right to revoke this authorization at any time and that further information about revocation is contained in our Notice of Privacy Practices. I understand if I revoke this authorization I must do so in writing and present my written revocation to Frederick P. Meserve, Jr., 65 Texas Avenue, Bangor, Maine 04401. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand revocation may be the basis for the denial of health benefits or other insurance coverage or benefits. If my authorization is obtained as a condition of obtaining insurance, I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself. Subsequent disclosures may be made pursuant to this authorization. Unless otherwise revoked, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I may refuse to disclose all or some health 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. I understand I may inspect or copy the information to be used or disclosed, and that I have a right to a copy of this authorization. I understand any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact Frederick P. Meserve, Jr., 65 Texas Avenue, Bangor, Maine 04401, Telephone 207-262-7937.

Signature:_______________________________________ Date:______________________________

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

Personal Representative:____________________________________ Date:____________________

Relationship to the Individual: ____

Describe Authority to Act for Individual: ____

RE-RELEASE 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.