

AUTHORIZATION For the Use and/or DISCLOSURE  
of PROTECTED HEALTH INFORMATION

University of Maine  
143 Corbett Hall  
Orono, Maine 04469  
(207) 581-2366

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ 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 University of Maine.

I hereby authorize the use of 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 \_\_\_\_\_

The University of Maine will only disclose information that it has generated unless additional information is specifically requested. Use "other" line below for this request.

Date 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)

\_\_\_\_\_ 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 Kathleen E. Bell, 143 Corbett Hall, Orono Maine 04469-5717. I understand the revocation will not apply to information that has already been released in response to this authorization. If I am a student, 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 to not sign this form in order to assure treatment. I may refuse to disclose all or some health information but, if I am a student, 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 the I have a right to a copy of this authorization. I understand any disclosure of information carries with it the potential for an unauthorized 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 Sharon Homsted, Privacy Officer, Orono Maine 04469, Telephone (207) 581-4191.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_  
(if under 18 years of age)

Date: \_\_\_\_\_

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