

AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS

MAINE BOARD OF LICENSURE IN MEDICINE

137 State House Station

Augusta, Maine 04333

Tel: (207) 287-3601

I, \_\_\_\_\_ of \_\_\_\_\_  
[Individual or authorized representative] [Address]

\_\_\_\_\_  
[City, State, Zip]

hereby authorize \_\_\_\_\_  
[Provider's name]

to release, disclose, and furnish the following individually identifiable medical and health care information regarding my care and treatment to the **Maine Board Of Licensure in Medicine, its agents and/or its attorney (hereafter Board)**.

\_\_\_\_\_  
[Insert patient name, date of birth and nature of health care information to be disclosed]

By checking below, I also authorize the release of the following portions of the health care records/information.

- |  |  |
|--|--|
| <input type="checkbox"/> Mental health treatment records<br><i>(Not including psychotherapy notes)</i> | <input type="checkbox"/> HIV or AIDS related records |
| <input type="checkbox"/> Alcohol or drug abuse records   | <input type="checkbox"/> Other _____<br>[Specify]    |
| <input type="checkbox"/> Medicaid records  |  |

**IMPORTANT:** If I have authorized the disclosure of **mental health treatment records/information**, I [ ] do [ ] do not want to review these records/information before it is released.

I understand that the review may be supervised or may need to be done by my representative.

**NOTICE** (applicable only if **substance abuse** records are disclosed).

The information disclosed includes records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit recipients of such records 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.

**Term of Authorization:** Except as provided hereinafter, this authorization shall be effective from the date I have signed it until \_\_\_\_\_. [Cannot exceed 30 months]

**Revoking the Authorization:** I have been advised I have the right to revoke this authorization by contacting the Board of Licensure in Medicine in writing to request this authorization be cancelled. If I revoke this authorization, the revocation will not apply to records/information that have been released before I notified the record keeper or the Board in writing of my change of mind. I understand that my decision to revoke this authorization may impair the Board's ability to investigate a complaint and to pursue disciplinary action against a licensee and my complaint may be dismissed.

**Purpose of Authorization:** I also understand the Board of Licensure in Medicine issues licenses to practice medicine in the State of Maine. The Board also investigates complaints or reports regarding licensed physicians and physician assistants in order to determine whether disciplinary action is needed in order to protect patients and the public interest. I understand that the information I am providing through this authorization will be used solely in connection with the pending investigation of a complaint or report against a licensee and any subsequent disciplinary proceedings.

**Redislosure:** I understand that the information used and disclosed in accordance with this authorization may be subject to redislosure by the Board of Licensure in Medicine as described above and may no longer be protected by the federal privacy rule. For example, the Board may disclose these records/information to the licensee, his or her attorney or a consultant hired by the Board or the licensee. However, I also understand that all individually identifiable health records/information provided to the Board of Licensure in Medicine pursuant to this authorization shall be considered confidential under Maine state law and shall not be used by the Board for any purpose other than that described above without my express written authorization, unless allowed by law.

**Copy of Authorization:** I acknowledge that I have retained a signed copy of this authorization. I agree that this authorization is as valid whether in the original, a photocopy, a facsimile, or in electronic form.

DATE: \_\_\_\_\_ SIGNATURE of Individual, or authorized representative\* \_\_\_\_\_ DATE OF BIRTH of patient \_\_\_\_\_

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
Relationship to individual\*

**\*If you are signing on behalf of the individual, please state your relationship to the individual on the line above and attach a copy of the order or document that authorizes you to sign and authorize release of the patient's records.**