UNIVERSITY OF MAINE SYSTEM
AUTHORIZATION to OBTAIN and/or DISCLOSE
HEALTH INFORMATION
(Not to be used for Psychotherapy Notes)

Name:_____ Student ID #_____ DOB: _____

Address: _____ Telephone: _____

Instructions: <u>Please complete all sections of this form.</u> Please note that incomplete or inaccurately completed forms will not be honored.

I hereby authorize the University of Maine System to ☐ obtain and/or ☐ disclose my health information as described below.

☐ All Records **or** ☐ Attendance ☐ Recommendations ☐ Diagnosis ☐ Treatment Plan ☐ Progress

☐ Psychiatric Evaluation Other (Please list)/Dates of Services _____

Release Information to or Obtain Information from:

(Name of Individual or Facility):_____

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I understand that authorizing the use or disclosure of this health information is voluntary.

I may refuse to allow disclosure of 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.

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 understand I have the right to revoke this authorization at any time by sending a written revocation to University of Maine, Counseling Center Director. 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 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.

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

If I have questions about use or disclosure of my health information, I may contact University of Maine, Counseling Center Director.

Signature: /MCID 2 >>BDC BT/F(9.5 2(Date) 428 T1 0 [illegible]