

**UNIVERSITY OF SOUTHERN MAINE
HEALTH & COUNSELING SERVICES**
Authorization for the Use and/or Disclosure

**156 Upton Hall
37 College Ave
Gorham, ME 04038
Ph: 207-780-5411 Fax: 207-780-4911**

Name: _____ Address: _____

Telephone: _____ Student ID#: _____ DOB: _____

UHCS Releasing Information to: Facility Name: _____
Address: _____

UHCS Obtaining Information from: City/State/Zip: _____
Telephone: _____ Fax: _____

List the type and amount of information to be used or disclosed, and dates of services (if applicable):

- Specific Records (List below) Women's Health Record including Pap Entire Record (Only IF required)

Specific Record(s): _____

Purpose of Use and/or Disclosure: COORDINATION OF CARE (Unless Otherwise Specified): _____

The following five categories require additional authorization to release. I DO is assumed unless the DO NOT space, found next to each, is initialed. You may choose to initial as many, or as few, I DO NOT lines as you deem appropriate:

- HIV status information:** I DO authorize the use and/or disclosure of health information related to testing, diagnosis or treatment of HIV, ARC or AIDS, pursuant to 5 M.R.S.A. Ch. 501. I DO NOT _____ (please initial)
- Substance Abuse Treatment Information:** I DO authorize use and/or disclosure of health information related to treatment, testing or diagnosis of alcohol or substance abuse pursuant to 42 U.S.C.290dd-2 and 42 CFR Part 2. Treatment information disclosed pursuant to 42 CFR Part 2 may not be re-disclosed without the Individual's express written authorization or as otherwise permitted by law. I DO NOT _____ (please initial)
- Mental Health Treatment Information:** I DO authorize use and/or disclosure of health information related to mental health treatment. Mental Health Treatment Information does not include "Psychotherapy Notes" under 45 CFR '164.501, which cannot be disclosed pursuant to this Authorization. I DO NOT _____ (please initial)
- Sexually Transmitted Disease Information:** I DO authorize use and/or disclosure of health information related to testing, diagnosis or treatment of Sexually Transmitted Diseases. I DO NOT _____ (please initial)
- Subsequent Disclosures:** I DO authorize subsequent disclosures to be made of the health information above. This does not apply to re-disclosure of alcohol or substance abuse treatment information disclosed under 42 CFR Part 2, under section (B) above. I DO NOT _____ (please initial)

I UNDERSTAND THAT:

- * I have the right to review this information at any reasonable time, including prior to its release. Review must be supervised.
- * I have the right to revoke this authorization at any time.
- * if I revoke this authorization I must do so in writing and present my written revocation to, Lisa Belanger, Director of Health Services for USM Health & Counseling Services.
- * the revocation will not apply to information that has already been released in response to this authorization.
- * revocation may be the basis for the denial of health benefits or other insurance coverage or benefits.
- * this authorization will expire in 30 months.
- * 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, 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 protected 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.
- * Partial or incomplete disclosures, as compared to the information requested to be disclosed, will be labeled as such.
- * I have a right to a copy of this authorization.
- * any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules.

If I have questions about disclosure of my health information, I may contact Lisa Belanger, Director of Health Services for USM Health & Counseling Services.

Signature: _____ or _____ Date: _____
(Student) (Parent/Guardian if minor < 18yrs)

- 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 University Health and Counseling Services.
- Re-disclosure of medical record information is strictly forbidden by recipients unless duly authorized by the patient

Information released FOR UHCS OFFICE USE ONLY:

Number of pages: _____ Method of Release (Please Circle): Mail Fax In Person Initials of sender: _____ Date _____