Authorization to Release Information
Maine Department of Labor
Bureau of Rehabilitation Services
We are committed to the Privacy of your information.

Which Division(s) should help you? Please check.

Division of Vocational Rehabilitation: ☐ Division for the Blind and Visually Impaired: ☐

VR Office Address: ____Fax#: __________

Whose information will be disclosed? Please print clearly.

Individual's Name:______________________________ Date of Birth: _______________________

Home Address: ____

Town/City: ________________ State: _____ Zip Code: __________Telephone: ________________

Email address(es) of individual/personal representative: ______________________________________

____

Please Check: Release/Send my information to: ☐ **or Obtain/Get my information from**: ☐

: ☐

Name of Individual: _________________ Organization: __________________________________

Address: ____Town/City: __________________

State: _____ Zip Code: ______________Telephone: __________________ Fax:__________________

Email addresses

(optional)____

For the Period of time from: ____________ to ____________, I authorize the following information to be released to the above entity: (please check all that apply)

- General Health Information: ☐ Medical /Psychiatric Hospital Records: ☐
- Psychiatric/ Psychological Evaluations (Diagnosis/Axis Codes): ☐ Medical Specialist Reports: ☐
- Occupational /Physical Therapy Eval: ☐ Psychiatric/ Psychological Comprehensive Assessments: ☐
- Substance Use Evaluations: ☐ Vocational Assessments and Plans: ☐ Psychiatric Progress Notes: ☐
- Educational /School Records: ☐ Ongoing Written and Verbal Information Exchange: ☐
- Other: ☐ ____

To share the information with others by EMAIL, please initial and complete the following:
I understand that email and the internet have risks that the office sharing my information cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask to send my information by email. **INITIAL HERE:** ________

State and Federal Laws require special permissions for release of the Following:
Check one Response for each of the statements below.

- Give permission for the release of information, which refers to drug/alcohol referral, diagnosis, or treatment. If I authorize the release of such information, I understand it cannot be re-disclosed by BRS without specific consent.

  I DO: ☐ I DO NOT:☐

- Give permission for the release of information, which refers to treatment or diagnosis of mental/behavioral health.

  I DO: ☐ I DO NOT: ☐

- Wish to review information, which refers to mental/behavioral health, before it is released. I understand any such review must be supervised.

  I DO: ☐ I DO NOT: ☐

- Give permission for the release of information, which refers to treatment or diagnosis of HIV infection, ARCS, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.

  I DO: ☐ I DO NOT:☐

I understand and Agree that:

- ❖ I can refuse to give some or all of the information in my treatment records, and also understand this could delay or cause denial of services.
- ❖ At any time, I can cancel all or part of this authorization by notifying my counselor named above, except to the extent that BRS has already acted on it, and also understand this could delay or cause denial of services.
- ❖ I am entitled to a copy of this release.
- ❖ BRS will not release any information about my disability to any other agency or person without the specific written consent of the individual.
- ❖ BRS may release information without my specific consent if I pose a direct threat to others or myself. BRS may release information without my specific consent if required by State or Federal law; in response to an investigation in connection with law enforcement; and in response to a court order.
- ❖ BRS may release information without my specific consent, for program audit, evaluation, or research purposes. The final product will not revealany personal identifying information.
- ❖ This release is effective for no more than one year from date of signing.

Date: ______________ Signature: ____

Personal Representative's authority to sign: ____
(Legal Guardian, Parent, or other)