AUTHORIZATION for the USE and/or DISCLOSURE
of HEALTH INFORMATION for RESEARCH
(Not to be used for Psychotherapy Notes)
UNIVERSITY OF MAINE SYSTEM
(Insert Entity Name, Address and Phone Number Here)

Study Title:____
____
____
Principal Investigator(s):____

Purpose of Authorization:
The Informed Consent Statement for this study requests your participation in a research study. This Authorization for the Use and/or Disclosure of Health Information for Research is a required supplement to the Informed Consent Statement. This Authorization does not change any of the information or permissions described in the Informed Consent Statement. The reason for a separate Authorization is a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA protects the privacy of certain personal health information contained in medical records, **but HIPAA does not apply to student medical records**. The University of Maine System, acting through ___________________________, ("University") has to obtain this separate Authorization from you, so it can disclose your protected health information for the medical research outlined in the Informed Consent Statement. This protected health information will be used for the research purposes described in the Informed Consent Statement for the study named above. 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.

Name:___________________________**Address:** ___________________________________
Telephone:________________ **Student ID #(Optional)** ______________ **DOB:** ________________

I hereby authorize the use and/or disclosure of my health information by the University and any employee or member of the workforce for the purpose of research as described above. The University will only disclose information that it has generated unless additional information is specifically requested. List the type and amount of information to be used or disclosed, and dates of service if applicable:____
____
____.

Release Information to: (Name or Facility): ____________________________________
Address:______________________________________ **City/State/ZIP**________________

I understand that my specific consent is required to use and/or disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. Please fill out all of the sections even if one or more of them are not applicable to you. Any of the following sections not completed will be presumed to be a refusal to authorize use and/or disclosure of such information. (The information below will not be FAXED even if disclosure is authorized.)

A) HIV status information. I DO__/DO NOT__ (Check one) authorize 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.

B) Substance Abuse Treatment Information. **I DO__/DO NOT__**(Check one) 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. Unless otherwise revoked this SPECIFIC authorization will expire on ________, 20___ or 6 months from the date of signing whichever comes first.

C) **Mental Health Treatment Information. I DO__/DO NOT__** (Check one) 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.

D) **Sexually Transmitted Disease Information. I DO__/DO NOT__**(Check one) authorize use and/or disclosure of health information related to testing, diagnosis or treatment of Sexually Transmitted Diseases.

Subsequent Disclosures: I DO__/DO NOT__(Check one) authorize the University to make subsequent disclosures of the health information identified above to the Individual or Facility identified 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.**

Potential for Redisclosure: Once your health information is disclosed by the University to the research team, it is no longer protected by HIPAA. By signing this Authorization, you allow that disclosure to the research team. Although HIPAA no longer protects your health information once it is disclosed to the research team, the research team will continue to protect your personally identifiable health information as described in the Informed Consent Statement. The University complies with all applicable laws that protect the confidentiality of your health information.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to____________________. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation 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 that authorizing the use or 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, than 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, than 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 understand that 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 or state confidentiality rules. If I have questions about disclosure of my health information, I may contact ____.

Signature:______________________________ Date: _____________________

IF NOT SIGNED BY THE INDIVIDUAL, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Parent/Guardian:____Date:_______________________
(If under 18 years of age)

Personal Representative:____________________________________Date:___________________

Relationship to the Individual: ____

Describe Authority to Act for Individual: ____

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