State of Maine Workers' Compensation Board
Limited Release of Protected Medical/Health Care Information Related to Psychological Matters

Name of Employee:
Date of Injury:
SSN (last 4 digits): XXX-XX- Date of Birth:
Description of Injury:

Notice to employer/insurer/employee: You may only use forms authorized by the State of Maine Workers' Compensation Board for the release of protected health care information to an employer or its insurer. The Board's forms may NOT be altered. Non-compliance may result in penalties.

Notice to health care providers: You are required to provide the records identified below to the recipient listed below within 30 days of receiving this signed authorization. You may also request that the employee sign a medical release acceptable to you pursuant to W.C.B. Rules Ch. 5 § 1.11 (3)(B).

This release permits the release of psychological treatment records by the following provider:

Name(s):
Address(es):

Insurer must choose one:
- ☐ We request only treatment records related to the date and description of injury listed above
- ☐ We request all treatment records from this health care provider

Employee must choose one:
- ☐ I consent only to the release of treatment records related to the date and description of injury listed above
- ☐ I consent to the release of all treatment records from this health care provider

Limited scope of treatment records: I understand this form authorizes the healthcare provider to release only written records. This form does NOT authorize oral communications with anyone other than me or my representative if I have one.

Timeframe: This release authorizes the disclosure of psychological treatment records dating from _____ until twelve (12) months after the date I sign this form.

Voluntary: I understand I have the right not to sign or complete this form. If I exercise that right, the insurer may deny my claim and file a Notice of Controversy ("NOC"). Please note: If a NOC is filed, a Troubleshooter from the Board will contact you and try to resolve the disagreement. More information is available here: https://www.maine.gov/wcb/employees.html

Redisclosure: I understand the records provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, my entitlement to workers' compensation benefits. Revocation of this authorization may only be accomplished by completing and sending WCB Form 220-R to the recipient listed below. This authorization may not be cancelled as to records already provided.

RIGHT TO REVIEW: You have the right to review your psychological counseling records prior to the authorized release of the records. You may add material to your record in order to clarify information you believe is false, inaccurate, or incomplete.

I DO ○ / DO NOT ○ (check one) want to review my records before they are released. By selecting I DO and signing below, I understand the review will be supervised and my review of the records prior to their release may delay the consideration of my claim.

I authorize the health care provider to release records to:
Name of Recipient/recipient's employer:

_____

Address of Recipient of records:

_____

Format Requested (select one):

Electronically (if available): _____

Fax to: _____

Mail to : _____

I hereby authorize the above named recipient to obtain records from my health care provider(s) subject to the terms of this release.

Employee signature _____

Date signed: _____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A)

WCB-220-A (effective 09/04/2023, revised 10/23/2023)