State of Maine Workers' Compensation Board Limited Release of Protected Medical/Health Care Information Related to Substance Use Disorder

Name:
Date Birth:
SSN (last 4 digits): XXX-XX-
Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms authorized by the State of Maine Workers' Compensation Board for the release of protected medical/health care information. 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 to the recipient indicated 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).

Notice to employee: The employer/insurer/employee representative contends your health care providers' records related to the identity, diagnosis, prognosis, or treatment of substance use disorder, regardless of the date of injury, are relevant to whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers, including 42 CFR Part 2 Program(s)_____ to release the records
(name of facility/provider/program)
they have related to the identity, diagnosis, prognosis, or treatment of substance use disorder. This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes my health care provider(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

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

Limited: I understand this form gives my health care providers permission to release only those health records related to the condition(s) listed above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: The information provided pursuant to this release may be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable. Please note: Redisclosure of information subject to 42 CFR Part 2 can only be redisclosed as provided by 42 CFR Part 2.

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, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. *Note: You may not cancel this release with respect to medical records already provided.*

I authorize release of my medical records to:

_____

Name of Recipient/Recipient's Employer

Address of Recipient:

_____

Format Requested (select one):
Electronically (if available): _____

Fax to: _____

Mail to : _____

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

Employee or Authorized Representative Signature: _____

Date: _____

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-B (effective 09/04/2023, revised 10/23/2023)