State of Maine Workers' Compensation Board
Revocation of Release of Protected Medical/Health Care Information

Name: SSN (last 4 digits): XX-XX-

Date of Birth: Date of Injury/Illness:

Notice to employee: This revocation must be sent to the recipient who is named on your release. You should provide a copy of this revocation to your health care providers as soon as possible. You should keep a copy of the signed form for your records. Your health care provider may not receive your revocation immediately and will continue to release your records until they receive a copy of this revocation.

I _____ am revoking the release of protected
(Name)

medical/health care information signed by me on _____ and provided to
(Date)

_____. This release revokes authorization for all health care providers,
(Recipient)

unless specified below:

☐ Only the following health care providers: _____

_____

I understand this revocation may result in a loss of or reduction in entitlement to workers' compensation benefits. I also understand this release does not apply to medical records already provided pursuant to the release.

I have read and understood this form.

I hereby revoke the release of my medical records:

Employee or Authorized Representative Signature _____

Date:_____

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

Notice to employer/insurer/employee representative: Within 14 days after receipt of this form you must forward a copy to all health care providers to whom you provided the release signed by the employee on the date listed above.

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