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

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

Date of Birth: 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 to an employer or its insurer. The Board's forms may NOT be altered. Non-compliance may result in penalties.

Notice to employee: The employer/insurer contends your medical records are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable. This means all written records relating to the diagnosis, treatment and care, including but not limited to diagnostic imaging/tests, related to the following body part(s) and/or condition(s):

_____

You have 14 days from receipt of this certificate to complete and return it to the employer/insurer. If you do not understand this form, talk with your legal representative. If you do not have a legal representative, a Workers' Compensation Board Claims Resolution Specialist can help you.

Notice to Health Care Practitions and Facilities: 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(2)(B)

_____

Employee Authorization to Disclose Protected Health Information ("PHI")/Health Care Information

I hereby authorize my health care providers to release the records, regardless of the date of injury, they have related to the diagnosis, treatment and care, including but not limited to diagnostic and imaging tests, of the body part(s) and/or condition(s) listed above subject to the following exclusions:

☐ None
☐ Exclusions: _____

This authorization does NOT authorize the release of information regarding testing, treatment or counseling related to: Psychological matters; substance use disorder; HIV/Aids and sexually transmitted diseases.

This authorization is to release written records only. It does not authorize oral communications with anyone other than me or my representative, if I have one.

This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes the above health care practitioners and/or facilities to release records pursuant to a later request after this release is signed through the termination date of this release.

Acknowledgements:

- **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: www.maine.gov/wcb/employees.html.

- **Redisclosure:** I understand the information 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, subject to the rights of any individual who acted in reliance on the authorization prior to receiving notice of revocation, 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. The WCB form 220-R is effective only after it is received and does not apply to information that was already disclosed.
- Upon my request, I am entitled to a copy of this authorization and to inspect or copy information disclosed hereunder.
- A copy of this Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this Authorization.

I authorize release of my medical records to: _____
(Name of recipient/recipient's employer)

Address of recipient/recipient's employer:

_____

Format Requested (select one): **Electronically (if available)**: _____ **Fax to**: _____

Mail to: _____

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