

Concealed Firearms Carry Permit Application Process

- Fill out application.
- Be sure to initial at the bottom of every page.
- Be sure to have someone witness your signature on page 7. (You may have your own witness or someone in this office may act as your witness).
- Return application to the **town office**, along with the appropriate fee; \$35 for new permits, \$20 for renewals, and \$2 for a change of address.
- **Permits expired for more than 6 months will be considered "new" and the \$35 fee will be charged.**
- The police department will contact you when your permit is ready. Please be patient, as this process can take up to 30 days or more.

Note: Effective 2/1/2013 applicants will be required to have some form of firearms safety training **before** a new Carry Permit can be issued. Proof of training should be submitted with your application. Examples of training include Hunter Safety, NRA Safety training and/or private instruction from a certified firearms instructor.

General questions concerning permits can be directed to office manager/dispatcher, Chris Reardon.

Dover-Foxcroft Police Dept: (207) 564-8021



STATE OF MAINE
APPLICATION FOR PERMIT TO
CARRY CONCEALED FIREARMS

(Resident)

NEW (\$35.00) RENEWAL (\$20.00)

CHANGE OF ADDRESS (\$2.00)

FOR OFFICE USE ONLY

CHECK # _____ \$35.00 \$20.00

LICENSE # _____ \$2.00

ISSUE _____ DENIED _____ DATE _____

EXPIRATION DATE (IF ISSUED) _____

KNOWLEDGE OF HANDGUN SAFETY _____

FULL NAME (First, Middle, Last) _____

PREVIOUS LEGAL NAMES, IF ANY (List month and year each name was given/assumed) _____ PHONE # _____

ALIASES, IF ANY (List year(s) used) _____

BIRTHDATE	BIRTHPLACE	CITIZEN (Y/N)	EYECOLOR	COLOR OF HAIR	HT	WT	SEX	RACE

MAILING ADDRESS (If different than legal residence) CITY OR TOWN STATE ZIP CODE _____

FULL CURRENT RESIDENCE ADDRESS CITY OR TOWN STATE ZIP CODE
(Street or Road Name, not P.O. Box) _____

LIST OF ALL ADDRESSES AT WHICH YOU HAVE LIVED AT ANY TIME DURING THE PAST FIVE (5) YEARS
(Street or Road, City/Town, State, Zip, Dates of residence) _____

LIST OF PREVIOUSLY ISSUED PERMITS TO CARRY CONCEALED FIREARMS OR OTHER CONCEALED WEAPONS BY ANY ISSUING AUTHORITY IN MAINE OR ANY OTHER JURISDICTION. For each permit previously issued, please identify the issuing authority (e.g. Massachusetts State Police; Portland P.D.; Town of Shapleigh, Selectmen) and the date the permit was issued. _____

LIST OF PREVIOUS REFUSALS TO ISSUE PERMIT TO CARRY CONCEALED FIREARMS OR OTHER CONCEALED WEAPONS BY ANY ISSUING AUTHORITY IN MAINE OR IN ANY OTHER JURISDICTION. For each refusal of a permit, please identify the agency that refused to issue the permit, and the date of refusal. _____

LIST OF PREVIOUS REVOCATIONS OR SUSPENSIONS OF FIREARMS PERMITS OR PERMITS TO CARRY CONCEALED FIREARMS OR OTHER CONCEALED WEAPONS BY ANY ISSUING AUTHORITY IN MAINE OR IN ANY OTHER JURISDICTION. For each revocation, please identify the agency or authority that revoked the permit and the date it was revoked or suspended. _____

PREVIOUS VERSIONS OF THIS FORM ARE OBSOLETE AND SHOULD NOT BE USED

CIRCLE APPROPRIATE ANSWER AFTER EACH QUESTION.

a. Are you less than 18 years of age?----- YES NO

b. Is there a formal charging instrument now pending against you in this state for a crime under the laws of this state that is punishable by imprisonment for a term of year or more?----- YES NO

c. Is there a formal charging instrument now pending against you in any federal court for a crime under the laws of the United States that is punishable by imprisonment for a term exceeding one year? ----- YES NO

d. Is there a formal charging instrument now pending against you in another state for a crime that, under the laws of the that state, is punishable by imprisonment for a term exceeding one year?----- YES NO

e. If your answer to question (d) is "yes", is that charged crime classified under the laws of that state as a misdemeanor punishable by a term of imprisonment of 2 years or less? ----- YES NO

f. Is there a formal charging instrument pending against you in another state for a crime punishable in that state by a term of imprisonment of 2 years or less and classified by that state as a misdemeanor, but that is substantially similar to a crime that under the laws of this State is punishable by imprisonment for a term of one year or more? ----- YES NO

g. Is there a formal charging instrument now pending against you under the laws of the United States, this State or any other state or the Passamaquoddy Tribe or Penobscot Nation in a proceeding in which the prosecuting authority has pleaded that you committed the crime with the use of a firearm against a person or with the use of a dangerous weapon as defined in Title 17-A, M.R.S.A. § 2 (9) (A)? ----- YES NO

h. Is there a formal charging instrument now pending against you in this or any other jurisdiction for a juvenile offense that, if committed by an adult, would be a crime described in question (b), (c), (d) or (f) and involves bodily injury or threatened bodily injury against another person? ----- YES NO

i. Is there a formal charging instrument now pending against you in this or any other jurisdiction for a juvenile offense that, if committed by an adult, would be a crime described in question (g)? ----- YES NO

j. Is there a formal charging instrument now pending against you in this or any other jurisdiction for a juvenile offense that, if committed by an adult, would be a crime described in question (b), (c), (d) or (f), but does not involve bodily injury or threatened bodily injury against another person? ----- YES NO

k. Have you ever been convicted of committing or found not criminally responsible by reason of insanity or mental disease or defect of committing a crime described in question (b), (c), (f) or (g)? ----- YES NO

PREVIOUS VERSIONS OF THIS FORM ARE OBSOLETE AND SHOULD NOT BE USED

- l. Have you ever been convicted of committing or found not criminally responsible by reason of insanity or mental disease or defect of committing a crime described in question (d)? _____ YES NO
- m. If your answer to question (l) is "yes," was that crime classified under the laws of that state as a misdemeanor punishable by a term of imprisonment of 2 years or less? _____ YES NO
- n. Have you ever been adjudicated as having committed a juvenile offense described in question (h) or (i)? _____ YES NO
- o. Have you ever been adjudicated as having committed a juvenile offense described in question (j)? _____ YES NO
- p. Are you currently subject to an order of a Maine court or an order of a court of the United States or another state, territory, commonwealth or tribe that restrains you from harassing, stalking or threatening your intimate partner, as defined in 18 United States Code, Section 921(a), or a child of your intimate partner, or from engaging in other conduct that would place your intimate partner in reasonable fear of bodily injury to that intimate partner or the child? _____ YES NO
- q. Are you a fugitive from justice? _____ YES NO
- r. Are you a drug abuser, drug addict or drug dependent person? _____ YES NO
- s. Do you have a mental disorder that causes you to be potentially dangerous to yourself or others? _____ YES NO
- t. Have you been adjudicated to be an incapacitated person pursuant to Title 18-A, Article V, Parts 3 and 4, and not had that designation removed by an order under Title 18-A, M.R.S.A. § 5-307 (b)? [Termination of incapacity, Probate Code; protection of persons under disability and their property] _____ YES NO
- u. Have you been dishonorably discharged from the military forces within the past 5 years? _____ YES NO
- v. Are you an illegal alien? _____ YES NO
- w. Have you been convicted in a Maine court of a violation of Title 17-A, M.R.S.A. § 1057 [possession of a firearm in an establishment licensed for on-premises consumption of liquor] within the past five (5) years? _____ YES NO
- x. Have you been adjudicated in a Maine court within the past five (5) years as having committed a juvenile offense involving conduct that, if committed by an adult, would be a violation of Title 17-A, M.R.S.A. § 1057 [criminal possession of a firearm in an establishment licensed for on-premises consumption of liquor]? _____ YES NO
- y. To your knowledge, have you been the subject of an investigation by any law enforcement agency within the past 5 years regarding the alleged abuse by you of family or household members? _____ YES NO

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z. Have you been convicted in any jurisdiction within the past 5 years of 3 or more crimes punishable by a term of imprisonment of less than one year or of crimes classified under the laws of a state as a misdemeanor and punishable by a term of imprisonment of 2 years or less? ----- **YES NO**

aa. Have you been adjudicated in any jurisdiction within the past 5 years to have committed 3 or more juvenile offenses described in question (o)? ----- **YES NO**

bb. To your knowledge, have you engaged within the past 5 years in reckless or negligent conduct [as defined at 25 M.R.S.A. § 2002(11)] that has been the subject of an investigation by a governmental entity? ----- **YES NO**

cc. Have you been convicted in a Maine court within the past 5 years of any Title 17-A, chapter 45 drug crime? ----- **YES NO**

dd. Have you been adjudicated in a Maine court within the past 5 years as having committed a juvenile offense involving conduct that, if committed by an adult, would have been a violation of Title 17-A, chapter 45? [Drugs offenses] ----- **YES NO**

ee. Have you been adjudged in a Maine court to have committed the civil violation of possession of a useable amount of marijuana, butyl nitrite or isobutyl nitrite in violation of Title 22 M.R.S.A. § 2383 within the past 5 years? ----- **YES NO**

ff. Have you been adjudicated in a Maine court within the past 5 years as having committed the juvenile crime defined in Title 15 M.R.S.A. § 3103 (1) (B) of possession of a useable amount of marijuana, as provided in Title 22 M.R.S.A. § 2383? ----- **YES NO**

[continued on next page]

**READ THE FOLLOWING CAREFULLY BEFORE SIGNING APPLICATION
BY AFFIXING YOUR SIGNATURE BELOW AS THE APPLICANT YOU:**

- A. Certify that the statements you have made on this application, and any documents you make a part of this application, are true and correct.**
- A-1. Certify that you understand that a “yes” answer to question (l) or (o) above is cause for refusal unless you are authorized to possess a firearm under Title 15 M.R.S.A. § 393.**
- A-2. Certify that you understand that a “yes” answer to question (p) is cause for refusal if the order of the court meets the preconditions contained in Title 15, M.R.S.A. § 393 (1) (D). If the order of the court does not meet the preconditions, the conduct underlying the order may be used by the issuing authority, along with other information, in judging good moral character under 25 M.R.S.A. § 2003 (4).**
- B. Certify that you understand that a “yes” answer to question number (a), (k), (n), or any of the questions numbered (q) through (x) above is cause for refusal.**
- B-1. Certify that you understand that a “yes” answer to one or more of the questions numbered (b) through (j), (m), (y), (z), or (aa) to (ff) above will be used by this issuing authority, along with other information, in judging good moral character under Title 25 M.R.S.A. § 2003 (4).**
- C. Certify that you will, that at the request of this issuing authority, take whatever action is required of you by law to allow this issuing authority to obtain from the Maine Department of Health and Human Services (limited to records of patient committals to Riverview Psychiatric Center and Dorothea Dix Psychiatric Center), the courts, law enforcement agencies, the military, the United States Citizenship and Immigration Services, and any prior issuing authority in this State or any other jurisdiction with which you have been involved, information relevant to the following:**
- (1) The determination as to whether the information supplied on the application or any documents made a part of the application is true and correct;**
 - (2) The determination as to whether each of the additional requirements of Title 25 M.R.S.A. § 2003 has been met;**
 - (3) The determination as to whether, if you are currently a permit holder, such permit must be revoked under Title 25 M.R.S.A. § 2005; and**
 - (4) The determination as to whether, if you are otherwise eligible and reapplying following an earlier revocation of a permit, you are eligible to do so under Title 25 M.R.S.A. § 2005 or Title 17-A M.R.S.A. § 1057.**
- D. Certify that you understand that if fingerprints are required by this issuing authority in order to resolve any questions as to your identity, you will submit to being fingerprinted.**
- E. Certify that you understand that if a photograph is an integral part of the permit to carry concealed firearms adopted by this issuing authority, you will submit to being photographed for that purpose.**

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- F. **Certify that you understand that you must demonstrate to this issuing authority a knowledge of handgun safety as required by Title 25 M.R.S.A. § 2003 (1) (E) (5), unless you demonstrate that you are exempted under that same statute.**
- G. **Certify that you have received a copy of the pamphlet entitled "LAWS RELATING TO PERMITS TO CARRY CONCEALED FIREARMS" (2005 edition).**
- H. **I understand that any false statements I make in this application or documents I make a part of this application may result in criminal prosecution pursuant to 25 M.R.S.A. § 2004 (1) and/or 17-A M.R.S.A. § 453, unsworn falsification.**

Your Signature as Applicant

Date

**ALL QUESTIONS MUST BE ANSWERED COMPLETELY
AND THE APPLICATION FEE (\$35 FOR ORIGINAL
APPLICATION, \$20 FOR RENEWAL APPLICATION,
OR \$2.00 FOR CHANGE OF ADDRESS)
MUST ACCOMPANY THIS APPLICATION OR
THE APPLICATION WILL BE RETURNED.**

**AUTHORIZATION TO PSYCHIATRIC FACILITY TO RELEASE INFORMATION
FOR THE PURPOSE OF APPLYING FOR A CONCEALED HANDGUN PERMIT**

PRINT LEGIBLY OR TYPE

NAME OF APPLICANT: _____ DOB: _____

ALIAS AND/OR PRIOR NAME(S): _____

Pursuant to 25 M.R.S. §2003 (1)(E)(1), I authorize the Riverview Psychiatric Center and the Dorothea Dix Psychiatric Center of the Department of Health and Human Services to disclose any record of whether I have ever been committed to the Riverview Psychiatric Center or the Dorothea Dix Psychiatric Center to the issuing authority:

Issuing Authority (individual)	_____		
Issuing Authority (organization)	I		
Mailing Address	_____		
Issuing Authority Fax #	_____	Telephone # to verify receipt of fax	_____

I understand that the information requested is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material prior to its release. I understand I have the right to revoke this authorization in writing at any time by contacting the issuing authority identified above. I understand that my refusal to sign this release will cause my application for a concealed handgun permit to be rejected. I understand that if the issuing authority receives an affirmative response to its inquiry, I may be asked to authorize the release of additional information to determine my eligibility for a concealed handgun permit. Information disclosed to the issuing authority pursuant to this release is confidential pursuant to 25 M.R.S. § 2006.

This authorization is effective for six months following the date of my signature.

Applicant Signature _____ Date _____

Witness Signature _____ Date _____

APPLICANT: DO NOT SEND THIS FORM TO THE HOSPITAL. YOU MUST RETURN THIS FORM TO THE ISSUING AUTHORITY IDENTIFIED ABOVE WITH YOUR PERMIT APPLICATION, OR YOUR APPLICATION MAY NOT BE PROCESSED.

ISSUING AUTHORITY: Send completed form (or a copy) to Riverview Psychiatric Center (RPC) AND to Dorothea Dix Psychiatric Center (DDPC) by one of the following means:

1. Scan form and send via **e-mail** to: RiverviewMedicalRecords@maine.gov **AND** DorotheaDixMedicalRecords@maine.gov **OR**
2. **Fax** form to: RPC: (207) 287-7127 **AND** DDPC: (207) 941-4029 **OR**
3. **Mail** the form, with a self-addressed stamped envelope to: Riverview Psychiatric Center, 250 Arsenal St., Augusta, ME 04330, Attn. Health Information; **AND** Dorothea Dix Psychiatric Center, PO Box 926, Bangor, ME 04401, Attn. Medical Records.

NOTICE TO ISSUING AUTHORITY: The RPC and DDPC will respond in the same manner in which you forward this form. However, if you fax the form, you must provide your telephone number so that the institution can verify your receipt of the return fax.

AG Form 6: Revised June 17, 2013
All previous versions of this form are obsolete.

**AUTHORITY TO RELEASE INFORMATION TO THE ISSUING AUTHORITY FOR THE
PURPOSE OF EVALUATING INFORMATION SUPPLIED ON MY APPLICATION FOR A
CONCEALED FIREARMS PERMIT UNDER 25 M.R.S.A. CHAPTER 252.**

**TO ALL LAW ENFORCEMENT AGENCIES, INCLUDING COURTS, BOTH WITHIN AND WITHOUT
THE STATE OF MAINE:**

**I hereby authorize and direct you to release to the issuing authority or its representative any
information in your possession or control concerning me pertaining to the following:**

- (1) conviction data;**
- (2) any criminal matter in which a formal charging instrument is now pending;**
- (3) adjudication data relating to any juvenile offenses which involves conduct which, if
committed by an adult, would be a crime;**
- (4) any juvenile matter in which a formal charging instrument is now pending involving any
juvenile offense described in (3) above;**
- (5) fugitive from justice status;**
- (6) incidents of abuse of family or household members within the past five years;**
- (7) drug abuse, drug addiction or drug dependency;**
- (8) adjudication as an incapacitated person;**
- (9) any mental disorder that causes me to be potentially dangerous to myself or others;**
- (10) reckless or negligent conduct as defined by 25 M.R.S.A. § 2002(11) within the past five years;**
- (11) information of record indicating that I have been convicted of or adjudicated as having
committed a violation of Title 17-A, chapter 45 or Title 22, section 2383, or adjudicated as
having committed a juvenile crime that is a violation of Title 22, section 2383 or a juvenile
crime that would be defined as a criminal violation under Title 17-A, chapter 45 if committed
by an adult; and**
- (12) whether I am currently subject to an order of a Maine court or an order of a court of the
United States or another state, territory, commonwealth or tribe that restrains me from
harassing, stalking or threatening an intimate partner, as defined in 18 United States Code,
Section 921(a), or a child of an intimate partner, or from engaging in other conduct that
would place an intimate partner in reasonable fear of bodily injury to that intimate partner
or the child.**

TO ALL PRIOR ISSUING AUTHORITIES, BOTH WITHIN AND WITHOUT THE STATE OF MAINE:

**I hereby authorize and direct you to release to the issuing authority or its representative any
information of record in your possession or control concerning me pertaining to any previous issuances of
refusals to issue and revocations of a permit to carry concealed firearms or other concealed weapons.**

AUTHORIZATION TO RELEASE INFORMATION

TO ALL MILITARY FORCES, BOTH STATE AND FEDERAL:

I hereby authorize and direct you to release to the issuing authority named below or its representative any information in your possession or control concerning me pertaining to a dishonorable discharge from the military forces within the past 5 years.

TO THE UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES:

I hereby authorize and direct you to release to the issuing authority or its representative any information in your possession or control concerning me pertaining to being an illegal alien.

TO ALL ABOVE-ADDRESSED GOVERNMENTAL ENTITIES:

I hereby authorize and direct you to release to the issuing authority named below or its representative any information in your possession or control concerning me pertaining to the following:

- (1) my full name;
- (2) my full current address and address for the prior 5 years;
- (3) the date and place of my birth and my physical description;
- (4) my signature.

Should there be any question to the validity of this release, you may contact me at the address and/or the telephone number listed below.

APPLICANT'S FULL NAME: (Typed or printed)	DATE: <u> </u> / <u> </u> / <u> </u>
APPLICANT'S FULL NAME: (Signature)	
DATE OF BIRTH OF APPLICANT:	
Mailing Address of Applicant:	
Telephone Number of Applicant:	

MAINE STATE POLICE
NAME OF ISSUING AUTHORITY

LT. David E. Bowler
NAME OF REPRESENTATIVE OF ISSUING AUTHORITY IF ANY

INFORMATION OBTAINED PURSUANT TO THIS RELEASE IS CONFIDENTIAL TO THE EXTENT PROVIDED BY 15 M.R.S.A. § 2006 AND MAY NOT BE MADE AVAILABLE FOR PUBLIC INSPECTION OR COPYING BY THE ISSUING AUTHORITY UNLESS THE CONFIDENTIALITY IS WAIVED BY THIS APPLICANT BY WRITTEN NOTICE TO THE ISSUING AUTHORITY.

THIS ORIGINAL RELEASE, AND ANY COPIES, ARE VALID FOR A PERIOD OF FOUR MONTHS FROM THE DATE OF SIGNATURE OF THE APPLICANT.

FOR THE PURPOSE OF APPLYING FOR A CONCEALED FIREARM PERMIT

PRINT LEGIBLY OR TYPE

NAME OF
APPLICANT: _____ DOB: _____

ALIAS AND/OR PRIOR
NAME(S): _____

Pursuant to 25 MRSA §2003 (1)(E)(1), I authorize the **Riverview Psychiatric Center** and the **Dorothea Dix Psychiatric Center** of the Department of Health and Human Services to disclose any record of whether I have ever been committed to the Riverview Psychiatric Center or the Dorothea Dix Psychiatric Center to the issuing authority:

Issuing Authority (individual): Lt. David E. Bowler

Issuing Authority (organization): Maine State Police Special Investigations Unit

Mailing Address: 164 State House Station, Augusta, ME 04333

Issuing Authority Fax#: 287-3424; Telephone # to verify receipt of fax: 624-7210

I understand that the information requested is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material prior to its release. I understand I have the right to revoke this authorization in writing at any time by contacting the issuing authority identified above. I understand that my refusal to sign this release will cause my application for a concealed firearm permit to be rejected. I understand that if the issuing authority receives an affirmative response to its inquiry, I may be asked to authorize the release of additional information to determine my eligibility for a concealed firearm permit. Information disclosed to the issuing authority pursuant to this release is confidential pursuant to 25 MRSA § 2006.

This authorization is effective for ninety (90) days following the date of my signature.

Applicant Signature

Date

APPLICANT: RETURN THIS FORM TO THE ISSUING AUTHORITY WITH YOUR PERMIT APPLICATION. RETAIN A COPY FOR YOUR RECORDS.

Admin Use Only

Acadia Hospital Corp.
AND / OR
 Acadia Healthcare, Inc.
268 Stillwater Avenue, PO Box 422
Bangor, Maine 04402-0422
Staff Assisting Patient: _____

* Patient Name: _____
* Patient DOB: _____
Patient MRN: _____

Authorization to Release or Obtain Health Care Information
Health Information Services Fax 207-973-6822

* I, _____, hereby authorize Acadia Hospital / Healthcare (circle one) to release and/or obtain my below-
Patient / Guardian Name
designated health care information to and/or from:

Agency / Individual: _____
Street _____ City or Town _____ State/Zip _____
Authorization by FAX to # _____ Attn: _____

Agency / Individual: _____
Street _____ City or Town _____ State/Zip _____
Authorization by FAX to # _____ Attn: _____

Agency / Individual: _____
Street _____ City or Town _____ State/Zip _____
Authorization by FAX to # _____ Attn: _____

Agency / Individual: _____
Street _____ City or Town _____ State/Zip _____
Authorization by FAX to # _____ Attn: _____

I authorize Acadia to **RELEASE** all of my relevant health care information (including information created after I sign this form) to the Agency/Individual identified above, **EXCEPT (check only those items you do NOT want released):**

- Date of admission/discharge
- Admittance history
- Progress notes
- Referral form
- Diagnosis information
- Discharge summary
- Medical consult
- Verbal communication
- Diagnostic tests/result
- Service dates from _____ to _____
- Other excluded information

I authorize Acadia to **OBTAIN** all of my relevant health care information (including information created after I sign this form) from the Agency/Individual identified above, **EXCEPT (check only those items you do NOT want obtained):**

- Date of admission/discharge
- Admittance history
- Progress notes
- Referral form
- Diagnosis information
- Discharge summary
- Medical consult
- Verbal communication
- Diagnostic tests/result
- Service dates from _____ to _____
- Other excluded information

* The purpose of this authorization is _____



100002263

If I wish to review this information prior to its release, I will check this box . Review must be supervised (utilize Supervision of Review of Psychiatric Records form). If I have been diagnosed or treated for any of the following, I understand that Acadia needs my specific consent to disclose related information. I may cross out any of the following which do not apply. In no event may any such information, if applicable, be disclosed without my specific consent. This authorization expires in one year unless I specify an earlier expiration date.
 Expiration Date (if any): _____

- 1. I DO DO NOT authorize **disclosure** of information about treatment or diagnosis of drug or alcohol abuse (Federal drug & abuse regulations, 42 CFR 2.31) including information within this category that is created after I sign this form. Such information may not be re-disclosed by the recipient without my specific written consent.
- 2. I DO DO NOT authorize **disclosure** of information about mental health treatment or diagnosis including information within this category that is created after I sign this form.
- 3. I DO DO NOT authorize **disclosure** of information which refers to treatment or diagnosis of HIV infection, ARC or AIDS including information within this category that is created after I sign this form. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance, and social and family relationships.
- 4. I DO DO NOT authorize Acadia to **obtain** information about treatment or diagnosis of drug or alcohol abuse (Federal drug & abuse regulations, 42 CFR 2.31) including information within this category that is created after I sign this form. Such information may not be re-disclosed by the recipient without my specific written consent.
- 5. I DO DO NOT authorize Acadia to **obtain** information about mental health treatment or diagnosis including information within this category that is created after I sign this form.
- 6. I DO DO NOT authorize Acadia to **obtain** information which refers to treatment or diagnosis of HIV infection, ARC or AIDS including information within this category that is created after I sign this form. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance, and social and family relationships.

- I understand that the Provider will not condition treatment on signing this authorization. The Provider will not deny me treatment if I do not sign this form. I may review my record before signing. I may refuse to sign this authorization form. Partial or incomplete information will be labeled as such. I understand that if I refuse to sign this authorization form, it may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.
- I also understand that I may revoke this authorization at any time, except to the extent that any person or organization has acted in reliance on the authorization prior to receiving notice of revocation and except with respect to information already disclosed. I understand that if I revoke this authorization, it may be the basis for denial of health benefits or other insurance coverage or benefits. To revoke my authorization, I will submit a written request to Acadia Health Information Services (address on front page) and to any agency or individual listed on the front page.
- I understand that if information other than information about diagnosis and treatment for drug and alcohol abuse (see #1 above) is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or organization that receives the information.
- A copy of this form will be provided to me upon my request.

I understand the matters discussed on this form. I release the Provider, its employees, officers and trustees, medical staff members, and business associates from any legal responsibility, or liability for the disclosures of the above information to the extent indicated and authorized herein.

* _____
 Signature of patient or guardian (signature requested for minors 14 or older) _____
Date / Time

 Signature of parent of minor, guardian or other legal representative _____
Relationship

If you are faxing or mailing this form for guardian consent, please include a copy of court guardianship paperwork.

Admin Use Only

Patient has a guardian other than parent of a minor
 Confirmation of guardianship: date/source _____