CITY OF WESTBROOK

Police Department
570 Main Street Westbrook, Maine 04092

Janine Roberts
Chief of Police

Phone – (207) 854-0644
Fax – (207) 854-0666

CONCEALED FIREARMS PERMIT APPLICATION

To the Resident Applicant:

Please complete and return this entire package with the following items:

☐ Application for Permit to Carry Concealed Firearms

Witness signatures along with applicant signatures are required on all Medical Release Forms

☐ Fee of **$35.00** for new applicants (If you are renewing and your permit expired over six months ago, you are considered a new applicant at the $35.00 fee), or a fee of **$20.00** for a renewal, or a fee of **$2.00** for a duplicate or a change of address made payable to: **City of Westbrook.**

☐ Copies of all concealed firearm permits issued by other states or municipalities within this state.

☐ A copy of your DD-214 form **if you were a member of the Armed Forces of the United States as proof of handgun safety.**

☐ A copy of your birth certificate or INS document.

☐ A copy of your Active State of Maine Driver's License.

☐ Proof of knowledge of handgun safety by submitting to the issuing authority, through documentation, that the applicant has, within the **5 years prior to the date of application, completed a course that included handgun safety** offered by or under the supervision of a federal, state, county or municipal law enforcement agency or a firearms instructor certified by a private firearms association recognized as knowledgeable in matters of firearms safety by the issuing authority or by the state in which the course was taken. Persons who are a member of the Armed Forces of the United States and has received at least basic firearms training, are exempt from this requirement.

If this is a **renewal** of a permit issued by the City of Westbrook and you have previously submitted the required military discharge papers, birth certificate or proof of knowledge of handgun safety, you are not required to submit these materials again. Please note that original copies of requested materials will not be returned.

Allow 4 to 6 weeks to process

MAKE CHECK PAYABLE TO: **CITY OF WESTBROOK**

		FOR OFFICE USE ONLY
	STATE OF MAINE APPLICATION FOR PERMIT TO CARRY CONCEALED HANDGUN – RESIDENT ☐ NEW ($35.00) ☐ RENEW ($20.00) ☐ DUPLICATE ($2.00) ☐ CHANGE OF ADDRESS ($2.00) ☐ CHANGE OF NAME ($2.00)	CHECK# _____ _____$35.00 _____$20.00 LICENSE# _____ _____$2.00 _____ISSUE _____DENY DATE:_____ EXPIRATION DATE IF ISSUED:

FULL NAME:

PRIOR LEGAL NAME(S):

ALIASES:

BIRTHDATE: EYE COLOR: HEIGHT: FT IN

BIRTHPLACE: HAIR COLOR: WEIGHT:

CITIZEN: Y N RACE: SEX: M F

EMAIL ADDRESS:

PHONE NUMBERS

CELL: HOME: WORK:

LEGAL MAILING ADDRESS:

LEGAL PHYSICAL ADDRESS:

LIST ALL ADDRESSES YOU HAVE LIVED AT DURING LAST 5 YEARS; **INCLUDE MOVE IN AND MOVE OUT DATES**; USE ADDITIONAL SHEET OF PAPER IF NEEDED:

	MO/YR IN – MO/YR OUT

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

AG FORM 1R REVISED 8/31/2015

Applicant Initials _____

LIST OF PREVIOUSLY ISSUED PERMITS TO CARRY CONCEALED HANDGUNS 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 HANDGUNS 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. (Include Explanations)

LIST OF PREVIOUS REVOCATIONS OR SUSPENSIONS OF HANDGUNS PERMITS OR PERMITS TO CARRY CONCEALED HANDGUNS 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. (Include Explanations)

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 imprisonent 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 Handgun 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

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 Handgun 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 Handgun 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

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? [Drug 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

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 Handgun 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 Handguns adopted by this issuing authority, you will submit to being photographed for that purpose.

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 HANDGUNS" (2014 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, DUPLICATE OR CHANGE OF NAME) MUST ACCOMPANY THIS APPLICATION OR THE APPLICATION WILL BE RETURNED.

AUTHORITY TO RELEASE INFORMATION TO THE ISSUING AUTHORITY FOR THE PURPOSE OF EVALUATING INFORMATION SUPPLIED ON MY APPLICATION FOR A CONCEALED HANDGUN PERMIT UNDER 25 M.R.S., 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. § 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 refusal to issue or revocation of a permit to carry handguns or firearms, or other weapons.

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 my status as 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.

DATE:	

APPLICANT'S FULL NAME: (Typed or printed)	
APPLICANT'S FULL NAME: (Signature)	
DATE OF BIRTH OF APPLICANT:	

Mailing Address of Applicant:	
Telephone Number of Applicant:	

Westbrook Police Department ISSUING AUTHORITY (Organization)	Chief Janine L. Roberts ISSUING AUTHORITY REPRESENTATIVE (Name)

INFORMATION OBTAINED PURSUANT TO THIS RELEASE IS CONFIDENTIAL TO THE EXTENT PROVIDED BY 25 M.R.S. § 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 SIX MONTHS FROM THE DATE OF SIGNATURE OF THE APPLICANT.

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)		**Chief of Police Janine L. Roberts**	
Issuing Authority (organization)		**Westbrook Police Department**	
Mailing Address		**570 Main Street, Westbrook ME 04092**	
Issuing Authority Fax#:	**(207)854-0666**	Telephone # to verify receipt of fax	**(207) 854-0644 ext. 2423**

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.

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)		**Chief of Police Janine L. Roberts**	
Issuing Authority (organization)		**Westbrook Police Department**	
Mailing Address		**570 Main Street, Westbrook ME 04092**	
Issuing Authority Fax#:	**(207)854-0666**	Telephone # to verify receipt of fax	**(207) 854-0644 ext. 2423**

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.

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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.

FAX: 662-4023

MaineHealth

144028

SHARED ELECTRONIC HEALTH RECORD

Patient Name: _____

Date of Birth: _____

Contact Phone: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize MAINE MEDICAL CENTER its authorized employees or agents
(Individual / Organization making disclosure)

to release information from my health record and speak with relevant persons concerning this information.

Send to (Name and Address): WESTBROOK POLICE DEPARTMENT
570 MAIN STREET WESTBROOK, ME 04092

Dates of Service: From _____ To _____

Specific Information to be released: for Psychiatric Evaluation (only)

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ ED Record
- ☐ Operative Report
- ☐ Pathology Report
- ☐ X-Ray Report
- ☐ Laboratory Reports
- ☐ Consult Report
- ☐ EKG
- ☐ Radiology Images
- ☐ Other (Specify): _____

I DO authorize the disclosure of any information relating to the diagnosis or treatment of **ALCOHOL or DRUG ABUSE**. If I authorize the release of this information, I understand that such information cannot be redisclosed by a recipient without my specific consent	I DO NOT: _____(initial here).
I DO authorize the disclosure of any information relating to the diagnosis or treatment of **MENTAL HEALTH**	I DO NOT: _____(initial here).
If I authorize the release of Mental Health, I DO NOT want to review the information before it is released.	I DO: _____ (initial here). I understand that such review must be supervised.
I DO authorize disclosure of information which refers to HIV test results or infection status or treatment information	I DO NOT: _____(initial here).

This disclosure is for the purpose of: Application for a Concealed Firearms Permit.

I understand that

- I can refuse to disclose some or all of the information in my treatment records, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences. I understand I will not be denied treatment for refusing to disclose information.
- I can revoke all or part of this authorization at any time during this time period by written notice to the Health Information Management Department except where information has already been acted upon for the release of my protected health information.
- I can cross out any provision on this form with which I disagree.
- if information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be redisclosed by the person or entity that receives this information.
- this release may not include records generated at other facilities unless expressly requested above.
- I understand I am entitled to a copy of this authorization, upon request.

This authorization is effective for one year from the date of signing. I authorize future disclosures to the same individual and/or entities during this time period.

_____ Signature of Patient

_____ Date

_____ Signature of Legally Authorized Representative

_____ Relationship and Date

_____ Printed Name of Authorized Representative

_____ Witness

Information Released

Pgs____ Date: _____

Method:

☐ in person → ☐ ID verified
☐ Fax ☐ Mail
☐ Paper ☐ Digital storage

Staff Initials _____

Pt. Initials_____

Original: Medical Record Copy: Patient

SPRING HARBOR HOSPITAL

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

NAME:

DOB:

IDENTIFICATION (NAME AND DOB)

I hereby authorize SPRING HARBOR HOSPITAL its authorized employees or agents
(Individual / Organization making disclosure)
to release information from my health record and speak with relevant persons concerning this information.

Send to (Name and Address): WESTBROOK POLICE DEPARTMENT
570 MAIN STREET WESTBROOK, ME 04092

Dates of Service: From _____ To _____

Specific information to be released: for: Psychiatric Evaluation (ONLY)

- XX Discharge Summary
- ☐ Medical H & P
- ☐ Diagnostic Tests
- ☐ Assessment
- ☐ Psychiatric Evaluation
- ☐ Medical Consultation
- ☐ Doctors Notes
- ☐ Crisis Response
- ☐ Progress Notes
- ☐ Medication Information
- ☐ Treatment Plan
- ☐ Statements by Patient
- ☐ Other Records – specify _____

~~I DO authorize the disclosure of any information relating to the diagnosis or treatment of ALCOHOL or DRUG ABUSE. If I authorize the release of this information, I understand that such information cannot be redisclosed by a recipient without my specific consent.~~	~~I DO NOT: _____ (initial here)~~
I DO authorize the disclosure of information which relates to HIV test results, infection status or treatment information.	I DO NOT: _____ (initial here)
~~I DO authorize the disclosure of any information relating to the diagnosis or treatment of MENTAL HEALTH.~~	~~I DO NOT: _____ (initial here)~~
If I authorize the release of Mental Health, I DO NOT want to review the information before it is released.	I DO: _____ (initial here). I understand that such review must be supervised.

This disclosure is for the purpose of:

- ☐ Ongoing Treatment / Aftercare
- ☐ To coordinate treatment efforts with family / concerned others
- ☐ At the request of the individual client/patient
- XX Other – specify: Concealed Firearms Permit Application.

I understand that:

- I can refuse to disclose some or all of the health care information in my treatment records, but that refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences. I understand I will not be denied treatment for refusing to disclose information.
- I can revoke all or part of this authorization at any time during this time period by written notice to the Health Information Management Department except to the extent that the action has already been taken in reliance upon it.
- I can cross out any provision on this form with which I disagree.
- If information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be redisclosed by the person or entity that receives this information.
- I understand that I am entitled to a copy of this authorization, upon request.

This authorization is effective for one year from the date of signing. I authorize future disclosures to the same individual and/or entities during this time period.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative Relationship and Date

_____ _____
Printed Name of Authorized Representative Witness and Date

Information Released

_____

_____

_____

Date Released: _____

Initials: _____

Office Use

123 Andover Rd. Westbrook, ME 04092 Tel 207-761-2363 Fax 207-774-6762

Patient Name:

Date of Birth:

Patient Identification: MRN# _____

Mercy Hospital
144 State Street
Portland, Maine 04101
p(207)879-3373 f(207)822-2469

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I authorize the EMHS entity indicated above to release my health information TO:

Name (entity or individual)	Phone#	Fax#	
WESTBROOK POLICE DEPARTMENT	(207)854-0644	(207)854-0666	
Street	**City**	**State**	**Zip**
570 MAIN STREET	WESTBROOK	ME	04092

Indicate the date(s) of service (such as admission date, visit date(s), date range etc.):

_____

Specific information to be released or comments/instructions:

_____

_____

PURPOSE: I release the above information for the purpose or purposes of:

[ ] On-going treatment/aftercare

[X] Release is to the requesting individual for personal use : Concealed Firearms Permit Application

[ ] Legal proceeding: Name of attorney: _____

[ ] Insurance matter: Name of insurance company: _____

Unless I revoke this authorization, it will expire in 12 months or upon the following date if sooner: _____.
NOTE: for purposes of disclosing information which refers to treatment or diagnosis of HIV infection or AIDS, this authorization will not expire.

Your specific consent is required to disclose any of the following types of information *(check the boxes only if you want this authorization to include this information)*:

☐ I authorize disclosure of federal drug or alcohol abuse program treatment information contained in my medical records. This information may not be re-disclosed by the recipient without my specific written consent.

XX I authorize disclosure of information derived from mental health services provided by a licensed mental health professional. The recipient of this information must be specified by name above.

☐ I want to review this information before it is released. I understand this review must be supervised. *(See back of page for a supervised review.)*

☐ I authorize the disclosure of information which refers to treatment or diagnosis of HIV infection or AIDS. 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 this authorization will stay in effect unless I later revoke this authorization. I understand that if I authorize the disclosure of this information to my insurance company, information which refers to treatment or diagnosis of HIV infection or AIDS may be disclosed to my current and future insurance companies, health plans, or payors unless I revoke or update this authorization.

Patient Name:

Date of Birth:

Patient Identification: MRN# _____

Mercy Hospital
144 State Street
Portland, Maine 04101
p(207)879-3373 f(207)822-2469

AUTHORIZATION TO RELEASE
HEALTHCARE INFORMATION

I understand that my treatment is not conditioned on signing this authorization. I will not be denied 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, denial of a claim for benefits, denial of other insurance or other adverse consequences.

I may revoke this authorization at any time except for the information already disclosed. To revoke my authorization, I will submit a written request to the Medical Records Department of the entity indicated above. I understand that, if I revoke this authorization, it may be the basis for denial of health benefits or other insurance coverage.

I understand that, if this information is disclosed to a third party or to me, the information may no longer be protected by state and federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand that this authorization applies to records created on or before the date indicated below unless related to this visit, a series of visits, or admission.

I understand that I may have a copy of this authorization form. I decline a copy of this authorization unless I ask for one to be given me.

I understand that I may be charged for copies of PHI as follows: $5 for the first page and $0.45 for each page following.

Signed: _____ Date: _____ Time: _____
(Patient*)

Signed: _____ Relationship: _____ Date: _____ Time: _____
(Patient Representative)

*A parent or guardian is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should also sign. If an adult is unable to make or communicate medical decisions, then the following may sign in the priority given: agent under healthcare power of attorney, guardian, spouse, next-of-kin. Indicate capacity of representative.

For Clinical Use Only Supervised Review of Mental Health Treatment Records

Any review of mental health treatment records by the patient must be supervised by the treating clinician or designee and documented below:

1. Date of Review: _____
2. Name of Person Supervising the Review: _____
3. This review: ☐ Is routine ☐ Involves reasonable concern of possible harmful effect to the patient
4. In cases where access of the guardian to the record would create documented imminent danger to the patient, was access to all or part of the record denied to the patient or the guardian? ☐ Yes ☐ No
5. If access was denied, explain the reason for the denial and indicate the portion of the record subject to the denial:
_____
_____

Signature of Reviewer: _____
Date/Time: _____