Form to share Mental Health/HIV Information

If you do not want to share your Mental Health/HIV information, do nothing with this form.

What is HealthInfoNet?
HealthInfoNet is a secure computer system that brings your health information from different healthcare providers into one statewide electronic health record. Your providers use this information to make better decisions about your care. It can also help them prevent mistakes, especially in an emergency. Your health record includes information about your medicines, allergies, test results, and more.

Are my records private and secure? HealthInfoNet encrypts all information and uses secure connections. Only those involved in your care can look at your information. To find out who has seen your record, visit www.hinfonet.org/audit. No system is completely secure, but HeathInfoNet makes every effort to keep your records safe.

Maine has separate rules about Mental Health/HIV information. This information is kept private *unless you indicate you want it shared*. You can authorize any provider to see your information at any time. Your other providers will only be able to see your information if you have a medical emergency. Your choice will not affect your ability to get medical care. If you decide later that you do not want to share your information, you can revoke your choice by contacting HealthInfoNet or by visiting www.hinfonet.org/patients/your-choices.

I choose to share my Mental Health/HIV Information.

Fill out this form and mail it to HealthInfoNet, 125 Presumpscot Street, Box 8, Portland, ME, 04103
or fax it to 207-541-9258.

This form must be witnessed and signed by healthcare staff, Notary Public, or HealthInfoNet staff. It needs to be handed to your participating provider or in person at HealthInfoNet's office.
If you are unable to do this, you may have the form notarized and mailed to us. Once we receive this form, your Mental Health/HIV information will be available to all your providers using HealthInfoNet.

Please check the box next to your choice(s)

☐ I choose ***to share*** my Mental Health information

and/or

☐ I choose ***to share*** my HIV information

____
First Name | Middle Name | Last Name

____
Address | City | State | Zip Code

Sex: □ Male □ Female

Date of Birth: ________/____/________ (month / day / year)

__ __ __ – __ __ – __ __ __ __
Social Security Number (not required)

____
Phone Number

____
Email

____
Signature of Patient or Guardian ***required***

_______/_______ /_______
Date (month / day / year)

____
Witness Signature ***required***

____
Witness Print Full Name ***required***

____
Healthcare Organization ***required***

On ___/____/_____, I attest that the above signer is personally known to me or established his/her identity by presenting government-issued photo identification.

If you have questions, call HealthInfoNet at 1-866-592-4352 or 207-541-9250, or email us at info@hinfonet.org