OLD TOWN POLICE DEPARTMENT
150 BRUNSWICK STREET
OLD TOWN, MAINE 04468

SCOTT J. WILCOX
CHIEF OF POLICE

TO THE RESIDENT APPLICANT:

Please review the copy of the booklet "Laws Relating to permits to Carry Concealed Handguns."
Please complete and return this entire package with the following items:

- Application for a Permit to Carry Concealed Handguns, pp. 1-6
- Authority and Authorization to Release Information forms must **BOTH** be filled out completely by the applicant whether applying for the first time or renewing. Return these forms with the application to the Old Town Police Department
- Fee of $35.00 for **NEW** applicants:
    - If your permit expired over 6 months ago, you are considered a **NEW** applicant and must pay the $35.00 fee **(Make check payable to: City of Old Town)**
    - A fee of $20.00 is required if you are a valid RENEWAL applicant (your permit is NOT more than 6 months expired, you have NOT changed your address more than 30 days prior without notifying the Issuing Authority);
    - A fee of $2.00 is required if you are requesting a DUPLICATE permit, a CHANGE OF ADDRESS or CHANGE OF NAME permit;
    - If you moved over 30 days prior without notifying us, not only are you a **NEW** applicant, your current permit is also invalid.
- If you hold a State of Maine issued permit from another Issuing Authority in Maine, include a complete copy of that permit with your application.
- If you are or were a member of the Armed Forces of the United States of America, a copy of your DD214 serves as proof of knowledge of handgun safety. You must have served long enough to complete basic firearms training. You also may NOT have a Dishonorable discharge from the Service.
- **NEW Applicants:** A copy of your Birth Certificate (BC) or INS document.
- **NEW Applicants:** A copy of a certificate which has been **issued within the past 5 years** that shows Proof of Knowledge of Handgun Safety (HGS).

MAKE CHECK PAYABLE TO: THE CITY OF OLD TOWN

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)

FOR OFFICE USE ONLY
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

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 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 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.

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 Scott Wilcox**		
Issuing Authority (organization)	**Old Town Police Department**		
Mailing Address	**150 Brunswick Street Old Town 04468**		
Issuing Authority Fax #	**(207) 827-3968**	Telephone # to verify receipt of fax	**(207) 827-3984**

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;11/19/2018 (change in issuing authority only
All previous versions of this form are obsolete.

Patient Identification

Name:

DOB:

Northern Light Health

- ☐ A.R. Gould Hospital
- ☑ Acadia Hospital
- ☑ Acadia Healthcare
- ☐ Beacon Health
- ☐ Blue Hill Hospital
- ☐ C. A. Dean Hospital
- ☐ Eastern Maine Medical Center
- ☐ Inland Hospital
- ☐ Lakewood
- ☐ Maine Coast Hospital
- ☐ Mercy Hospital
- ☐ Northern Light Home Care & Hospice
- ☐ Northern Light Laboratory
- ☐ Northern Light Medical Transport
- ☐ Northern Light Pharmacy
- ☐ Sebasticook Valley Hospital
- ☐ Work Health

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PLEASE FAX FORM TO HIM DEPARTMENT LISTED BELOW

	Phone	Fax		Phone	Fax
A.R. Gould Hospital	(207) 768-4175	(207) 768-4060	Lakewood	(207) 873-5125	(207) 861-9967
X Acadia Hospital	(207) 973-6100	(207) 973-6822	Maine Coast Hospital	(207) 664-5454	(207) 665-5398
X Acadia Healthcare	(207) 973-6100	(207) 973-6822	Mercy Hospital	(207) 879-3373	(207) 822-2469
Beacon Health	(207) 973-5692	(207) 989-1096	Northern Light Home Care & Hospice	(800) 757-3326	(207) 400-8891
Blue Hill Hospital	(207) 374-3458	(207) 374-3971	Northern Light Laboratory	(207) 973-6900	(207) 973-6999
C. A. Dean Hospital	(207) 695-5225	(207) 695-2254	Northern Light Medical Transport	(207) 275-2940	(207) 973-9487
Eastern Maine Medical	(207) 973-7873	(207) 973-7867	Northern Light Pharmacy	(207) 275-3216	(207) 561-4804
Inland Hospital	(207) 861-3150	(207) 861-3158	Sebasticook Valley Hospital	(207) 487-4026	(207) 487-3204

NONDISCRIMINATION STATEMENT: Northern Light Health and its affiliates (Northern Light Health) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language. Northern Light Health does not exclude people or treat them differently because of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language.

Northern Light Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-888-986-6341. If you have a TTY, you may also dial 711 Maine Relay.

If you believe that Northern Light Health or any of its affiliates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language, you can file a grievance with your Northern Light Health Civil Rights Coordinator, 797 Wilson St., Suite 4, Brewer, ME 04412, 1-866-769-8363 **(telephone),** 1-207-989-1420 **(fax),** or at nondiscrimination@northernlight.org **(email)**. If you need help filing a grievance, your Northern Light Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-986-6341 (ATS : 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-986-6341 (TTY: 711).

Oromo (Cushite): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-986-6341 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-986-6341 （TTY：711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-986-6341 (TTY: 711).

Tagalog (Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-986-6341 (TTY: 711).

Cambodian (Khmer): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ *1-888-986-6341 (TTY: 711)*។

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-986-6341 (телетайп: 711).

Arabic:

(رقم*1-888-986-6341*ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
هاتف الصم والبكم: *711*.)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-986-6341 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-986-6341 (TTY: 711)번으로 전화해 주십시오.

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-986-6341 (*TTY:* 711).

Nilotic (Dinka): PIƆ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-888-986-6341 (TTY: 711)

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-986-6341 （TTY:711）まで、お電話にてご連絡ください。

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-986-6341 (TTY: 711).

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I authorize the Northern Light Health entity indicated above to release my health information to:

Name (entity or individual) Old Town Police Department ATTN: Chief Scott Wilcox		Phone 207-827-3984 fax: 827-3968	
Street 150 Brunswick Street	City Old Town	State ME	Zip 04468
Name (entity or individual)		Phone	
Street	City	State	Zip
Name (entity or individual)		Phone	
Street	City	State	Zip
Name (entity or individual)		Phone	
Street	City	State	Zip

NOTE: All disclosures based on this form are limited to records existing at the time the form is signed, unless you (the patient or personal representative) indicate below that you want us to release records related to specific future tests, procedures, appointments, etc.

Indicate the date(s) of service (such as admission date, visit date(s), date range, etc.) (including instructions on release of future records): _____

_____

Specific information/documents to be released or comments/instructions (e.g., the particular practice or department from which to release the records):

_____

_____

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

☐ On-going treatment/aftercare

☐ Release is to the requesting individual for personal use

☐ Legal proceeding: Name of attorney: _____

☐ Insurance matter: Name of insurance company: _____

This authorization will expire in 12 months unless I give an earlier expiration date here: _____.

NOTE: for purposes of disclosing information which refers to treatment or diagnosis of HIV infection or AIDS, this authorization will not expire and will remain in effect unless revoked.

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.

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

☐ I want to review my behavioral health information before it is released. I understand this review must be supervised (Northern Light Acadia Healthcare or Northern Light Acadia Hospital patients only).

☐ 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.

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 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.

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

Signed: _____ Relationship: _____ Date: _____ Time: _____
(Authorized Representative*)

*A parent /guardian or other authorized representative is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should sign in addition to their parent/guardian or other authorized representative. If a minor patient consented to his/her own care, the minor patient must sign this authorization form to release records related to that care. Indicate relationship of representative to patient.

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:	

Old Town Police Department **ISSUING AUTHORITY (Organization)**	Chief Scott Wilcox **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.