

**AUTHORIZATION TO RELEASE INFORMATION**  
**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): \_\_\_\_\_

Issuing Authority (organization): \_\_\_\_\_

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 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.

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Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

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Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

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

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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: RPC: [elaine.m.wyman@maine.gov](mailto:elaine.m.wyman@maine.gov); and DDPC: [kathy.l.browne@maine.gov](mailto:kathy.l.browne@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: RPC: 250 Arsenal St., Augusta, ME 04330, Attn. Health Information; and DDPC: 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.