Maryland
DEPARTMENT OF HEALTH

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Use a separate form for each individual, program, organization or facility with which information may be shared.
Please type or print as clearly and completely as possible.

1 **Patient name** _____ **Date of Birth** _____

2 **I hereby authorize and request the following party to ☐ release ☐ receive information**

_____
Name of individual, program, organization or facility

_____
address

3 **☐ to ☐ from the following party** _____
Name of individual, program, organization or facility

_____
address

4 **The following information (INITIAL all items covered by this authorization):**

_____ **Acknowledgment of receipt of services**

_____ **Complete program record (includes all items below):**

_____ Intake assessment _____ Treatment plan _____ Progress notes _____ Diagnosis

_____ History/Physical _____ Lab Results _____ Service/discharge summary

_____ Medications _____ Immunizations _____ Identifying Information

_____ Billing Records _____ Photographs, Video, Digital or other images

_____ Mental health _____ Records from other providers contained in the program record

_____ **Other (specify)** _____

_____

_____ **Alcohol or other drug treatment records (requires specific authorization). Specify below.**

_____ Complete record _____ Assessment results/history _____ Treatment/service plan progress/compliance

_____ Other (specify) _____

5 **The disclosure is for the following purpose(s) (Check all that apply):**

☐ Patient request ☐ Treatment/continued care ☐ Review current care

☐ Payment ☐ Insurance application ☐ Legal

☐ Other (please explain) _____

_____

6 **This authorization expires one year from the date the form is signed unless I indicate an earlier date or event *(must occur sooner than 1 year from the date of my signature)* here:**

Until Date: _____ **OR** Until specific event: _____

7 **I understand the following:**

a. By signing this form, I am authorizing that the health information specified in Section 4 be shared between the party named in section 2 and the party named in section 3.

b. I may revoke this authorization at any time by writing to the individual(s), program(s), organization(s) or facility/facilities authorized to release information. If more than one individual, program, organization or facility has been authorized to release information, a written revocation request must be submitted to each party.

c. If an individual, program, organization or facility has already released health information based on this authorization, revoking it will only prevent future disclosure by the party to whom a written revocation has been submitted.

d. My treatment, payment for my treatment, enrollment or eligibility for services/benefits cannot be conditioned on the signing of this authorization, unless authorization is required to determine eligibility for services/benefits.

e. The information disclosed may be subject to redisclosure by the recipient and no longer protected by HIPAA.

8 **Patient Signature** _____ **Date** _____

Parent or Personal Representative Signature *(if applicable)* _____ **Date** _____

If signed by Parent or Personal Representative, please indicate Relationship to Patient

⬜ Parent of Minor Child ⬜ Guardian ⬜ Authorized Representative

⬜ Other_____

NOTICE

Any individual, program, organization or facility receiving information pursuant to this release is prohibited from redisclosing the information without the express, written consent of the patient. The information disclosed may be used only for the purpose(s) stated above.

If the information disclosed pursuant to this authorization contains information pertaining to alcohol or drug abuse treatment, diagnosis of alcohol or drug abuse or any referral for treatment of alcohol or drug abuse, 42 CFR Part 2 prohibits the unauthorized disclosure of these records.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the requested records.