# [Individual/Patient/Client/Insured]:

Printed Name of Individual/Previous Names: Street Address



Birth Date: City, State, Zip



# AUTHORIZES:

Individual(s)/agency/organization making disclosure:

# DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Individual/agency/organization receiving information:

Street Address Street Address



City, State, Zip Code City, State, Zip, Phone, Fax



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# INFORMATION TO BE USED &/or DISCLOSED:

The following is a specific description of the health information I authorize to be used and/or disclosed:

* Intake Forms
* Evaluations
* Plan of Care
* Treatment Notes
* Progress Notes
* Other:

In compliance with MD Statutes, which require special permission to release otherwise privileged information please release records pertaining to: [Check all that apply]

* Mental Health
* Developmental Disabilities
* Alcohol &/or Drug Abuse
* HIV Test Results

Other (Specify):



For the Following Date(s): From To .

**PURPOSE FOR NEED OF DISCLOSURE:** (Check applicable categories)

* At the request of the Patient
* Further Medical Care
* Claims Resolution
* Other (Specify):
* Coordinating Care for Dependent/Spouse
* Insurance Eligibility/Benefits

**TERMINATION.** This authorization is good until [indicate date or event]

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**REVOCATION RIGHTS**. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person, or entity, has already acted in reliance on my authorization, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

**BENEFITS.** I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

**REDISCLOSURE NOTICE**: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal or State privacy laws or standards.

By signing this authorization, I am confirming that it accurately reflects my wishes.

Patient Signature: Date:

Signature of Witness: Date:

Printed Name of Witness:

\*If applicable, Legal Representatives sign below:

*By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member’s behalf with respect to this authorization form.*

Signature of Legal Representative: Date:

Printed Name of Legal Representative: