7101 Guilford Drive,Phone: 240-464-8000
Suite 100Fax: 240-383-3439
Frederick, MD 21704

6237 Executive Blvd.
Rockville, MD 20852

CONSENT FOR RELEASE OF INFORMATION

Name:	**DOB:**	**Date:**

NOTICE TO RECIPENT OF INFORMATION

This information has been disclosed from records, confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making and further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains, or as otherwise permitted by 42 CFR Part 2 A general authorization for the release of medical or other information in NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION

I hereby authorize Medpsych Health Services to **(check all that apply)**

☐ Release/Communicate any applicable mental health information to the Provider named below:
Please circle all that applies (medical records, lab results, school records, testing results, psychotherapy notes)

☐ Release/Communicate any applicable substance abuse information to Provider named below.

Provider's Name:	Phone:
Address:	Fax:

Purpose of Disclosure: (please circle all that applies)
Worker's comp, leaving practice, Relocating, Disability Determination, Legal investigation, School, CPS, PCP, Other: ___________________

I understand that there may be a charge for a personal copy or the permanent transfer of your records.
According to "Maryland Health General-Article Section 4-304" your charges will be applied as "record search fee $22.88" and charges per page $.76 (for pages 1-35) and $.20 (for pages 36 and above).

I understand that I have the right to refuse to sign this Authorization to release the Protected Health Information.

I understand that this authorization is voluntary and I need not to sign this form in order to assure treatment.

I understand that I may revoke this authorization at any time by signing a written request, except to the extent that action has been taken in reliance upon it.

This authorization will expire one year from the date signed or on the __________, 201__.

I acknowledge that the material authorized for release may contain alcohol/chemical dependency and/or psychiatric information.

This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "authorization to Release of Protected Health Information".

I, undersigned, have read the above and authorize ____ to disclose such information as described within the document about me/my child.

_______________________________ _________________________________ _________________________

(Signature of Patient / Parent / Guardian) (Print Name of Patient / Parent / Guardian) (Date)

In case of a guardian for minor, legal documents must be provided.
(RApril 2014)

Authorized by (office use only): ________________________________