HOUSE of HOPE
MARYLAND
Healing Teens • Restoring Families • Transforming Communities

Release of Information

PO 214 Ashton, Maryland 20861 • Phone (301) 774-3804

You may complete a separate release for each sending/receiving location, or you may leave the Name of Sending/Receiving Location blank, authorizing reuse of release as necessary.

Student Information

_____ _____ _____

Full Name DOB Telephone

_____

Address, City, State, Zip

Release Authorization

_____ _____

Individual Granting Permission for Release (if different from student) Title or Relationship to student

_____ _____

Telephone (if different from above) Email

I hereby authorize the Director, Teacher and/or Counselor at House of Hope Maryland Day School to:

☐ Send ☐ To ☐ Receive ☐ From

_____ _____ _____

Name of Outside Sending or Receiving Location Phone Fax

_____

Address of Outside Sending or Receiving Location (include City, State, Zip)

Scope of Release

Information received by House of Hope Maryland Day School will be used for the following purposes: determining eligibility for placement, planning appropriate program, continuing appropriate program, case review.

Permission Granted For (check all that apply)

☐ Permission for release of all areas below including tests, forms, reports, and other pertinent information

☐ Academic testing results

☐ Individualized Education Plan

☐ Medical reports

☐ Psychological testing results/reports

☐ Service plans

☐ Other, specify: _____

Notes or Limitations _____

Disclaimer for Authorization and Signature I authorize the release of the above named student's confidential protected information, as described in my directions above. I may revoke this authorization at any time in writing, except to the extent action has already been taken. The information used and/or disclosed pursuant to this authorization may be re-disclosed by recipient unless recipient is covered by state laws that limit use and/or disclosure of my confidential protected information and may no longer be protected by federal privacy regulations. I understand there are legal and ethical requirements that mandated reporters take responsible action in those situations as prescribed by law where there is danger of imminent harm to self or others, and in the case of apparent child abuse. I have been informed what information will be given, its purpose, and who will receive it. I understand I have a right to receive a copy of this authorization. If I am the legal guardian or representative appointed by the court for the client, I must attach a copy of the authorization to receive this protected information.

_____ _____ _____

Signature Title or Relationship Date

Release expires one year after end of client's treatment unless otherwise revoked. Information has been disclosed from confidential records. Further disclosure without the specific written consent of client exceeds the limits of this release. Revised 07/2017