# Marshy Hope Family Services, LLC
## Authorization for Release of Information

To be valid, this form must be filled out completely.

Patient Name: _____ Date of Birth: _____
Social Security Number: _____ Telephone No.: _____
Client Address: _____
_____

I hereby authorize Marshy Hope Family Services, LLC:
(Please initial appropriate line(s))

_____To Release Information To: _____To Obtain Information From:
_____Verbal Communication _____Ongoing Interagency Communication

_____
(Name of Person) Organization) (Phone)

_____
(Street Address) (City) (State) (Zip Code)

I understand that the specific type of information to be disclosed includes:
(Please initial items to be released and provide dates where appropriate)

_____Discharge Summary
_____Physical Exam & History
_____Psychological Testing
_____Lab/Testing Report
_____Individual Treatment Plan: Date(s)_____
_____Individual Rehab Plan: Date(s)_____
_____Psychiatric Progress Note(s): Date(s)_____
_____PRP Contact Notes: Date(s)_____
_____Immunization Records
_____Medication Orders
_____Aftercare Plan
_____School/Educational Records
_____Initial Assessment
_____Other: (Please specify)_____

I understand that the information may include treatment for behavioral, mental, and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or tests for HIV or AIDS.

The purpose of this disclosure is: (please initial all that apply)

_____Evaluation & Treatment Planning
_____Assist with Legal Issues
_____Inform Family Member
_____Job Recommendations
_____Coordination of Services
_____Disability Claim
_____Inform Employer
_____Other:_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not by protected by confidentiality rules.

I understand that I may revoke this authorization in writing at any time. Otherwise this authorization is valid for one year after the date of signature or

_____
(Specification of date/event or condition upon which consent expires)

Signature:_____ Date:_____
If signed by parent/legal guardian, relationship to patient:_____
Witness:_____ Date:_____

Any individual or agency receiving this information is prohibited from making any further disclosure of this information without the specific written consent of the person to whom it pertains (or that of their legal representative), except in those cases consistent with Maryland State or Federal Law, statute, or regulation whereby this information must be produced or otherwise examined.