Marshy Hope Family Services, LLC
Authorization for Release of Information (Other Mental Health Provider)

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))

X To Release Information To: X To Obtain Information From:
X Verbal Communication X 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)

X Discharge Summary
_____ Physical Exam & History
X Psychological Testing, if applicable
_____ Lab/Testing Report
X Individual Treatment Plan: Date(s) most recent
_____ Individual Rehab Plan: Date(s) _____
X Psychiatric Progress Note(s): Date(s) last 3 months
_____ PRP Contact Notes: Date(s) _____
_____ Other: (Please specify) _____
_____ Immunization Records
X Medication Orders
X Aftercare Plan
_____ School/Educational Records
X Initial Assessment

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)

X Evaluation & Treatment Planning
_____ Assist with Legal Issues
_____ Inform Family Member
_____ Job Recommendations
X 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.