Marshy Hope Family Services, LLC
Authorization for Release of Information (Physician)

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 Primary Care Physician) (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 X_____Immunization Records
X_____Physical Exam & History X_____Medication Orders
_______Psychological Testing _______Aftercare Plan
X_____Lab/Testing Report _______School/Educational Records
_______Individual Treatment Plan: Date(s)____________ _______Initial Assessment
_______Individual Rehab Plan: Date(s)_______________
_______Psychiatric Progress Note(s): Date(s)__________
_______PRP Contact Notes: Date(s)_________________
_______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 X_____Coordination of Services
_______Assist with Legal Issues _______Disability Claim
_______Inform Family Member _______Inform Employer
_______Job Recommendations _______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.