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

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(s) of School Staff) (School Name) (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	_____ Immunization Records
_____ Physical Exam & History	X Medication Orders
X Psychological Testing	_____ Aftercare Plan
_____ Lab/Testing Report	X School/Educational Records
_____ Individual Treatment Plan: Date(s)_____	_____ Initial Assessment
_____ Individual Rehab Plan: Date(s)_____	X IEP or 504 Plan
_____ Psychiatric Progress Note(s): Date(s)_____	X PowerSchool information
_____ PRP Contact Notes: Date(s)_____	

X Other: (Please specify) behavioral records or rating scales _____

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.