

Mid Shore Behavioral Health, Inc.

Authorization for Release of Confidential Information

Please fax requested materials to 410-770-4809

Name: _____

Date of Birth: _____

Address: _____

Release of Information

I hereby authorize: _____ or Mid Shore Behavioral Health, Inc.

_____ and

To release health information, including psychiatric and substance abuse records, from the medical records of the above-named person for the following purpose: clarify diagnosis, formulate a treatment plan and aftercare.

Release information to:

Mid Shore Behavioral Health, Inc. or _____
and

For treatment date(s): _____ or Any/all previous treatment dates at your facility

Type of information requested:

- Discharge Summary Social Work Summary Day Treatment Records Lab reports
 Admission Summary Drug Treatment Medication History IEP
 Psychological testing Other _____

This authorization will expire one year from the date signed below unless specific expiration date or condition is named here: _____. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this authorization for Release of Confidential Information and authorizing the disclosure is voluntary. I understand I may inspect the information to be used or disclosed, as provided in CFR 186.524.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I acknowledge that the material authorized for release may contain, alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 CFR pts. 160 and 164. This entity is released and discharged from any liability and the undersigned will hold the facility harmless for complying with this "Authorization for the Release of Confidential Information."

Date _____

Signature _____

Date _____

Witness _____