PRIVACY RELEASE

Authorization for Montgomery County Covered Component to Share Information with Elected Officials

Information that Montgomery County Department of Health and Human Services (DHHS) or Fire and Rescue Services (MCFRS) maintain about you is confidential based on numerous federal and state laws. These Departments cannot share information about you with elected officials without your written authorization. Please complete the information below so that we can assist you.

Name: ____ Date of Birth: __________________

Address: ____ Phone: ________________________

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Email: ____

Note: Use of email may compromise the privacy and security of your information.

I authorize staff in the office of ________________________________ to make inquiries on my

Name of Elected Official

behalf and for DHHS/MCFRS to share information about my case or application with such staff as necessary to address my request.

Below is a description of my concern for which I would like assistance. *Please be specific. If necessary, attach a short letter and copies of any relevant documents or notices. Include the name and location of the DHHS program and the name of your DHHS worker, if known.*

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This authorization is valid until the above request has been addressed, but in any event will automatically expire one year from the date this authorization is signed.

I understand I can revoke this authorization at any time by submitting a request in writing to DHHS or MCFRS program staff. A revocation will become effective the date it is received by DHHS or MCFRS staff and does not apply to information that has already been shared. I understand that if this authorization pertains to alcohol or other drug treatment records protected by federal regulations at 42 C.F.R. Part 2, I can orally revoke this authorization, and my records may not be re-disclosed without my written consent or as permitted by the regulations. I understand that if the person or organizations I authorize to receive and or use my information are not subject to federal or state privacy laws, this information may no longer be protected and could be disclosed.

____ ______________________________

Signature of DHHS/MCFRS Client *Date*

____ ______________________________

Signature of parent, guardian, or other authorized person *Date*

PLEASE RETUREN THIS SIGNED AND DATED FORM AND ALL SUPPORTING MATERIAL

TO : ____