H-1

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Montgomery County Department of Health and Human Services

Program/Service Area Fill in name of your program here.
Address _____ Phone _____
_____ FAX _____

Please print all information. Use a separate form for each person or agency with which information may be shared.

Client Last Name	First Name	Middle Initial	Date of Birth	Sex ☐M ☐F

1. The above named program of the Montgomery County Department of Health and Human Services (DHHS) has my permission to:
☒ **send to** ☒ **receive from** ☒ **verbally discuss the information checked below with:** ← check all 3 boxes
Agency/Individual: List all agencies/individuals here, or write "See Attachment" ← The attachment will list all agencies/individuals. client initials attachment.
Address: _____

2. *Initial all items covered by this release.*
initial **Acknowledgment of receipt of services**
initial **Complete program record (includes all items below)** ← Check all that are applicable
_____ Intake Assessment _____ Treatment Plan _____ Progress Notes _____ Diagnosis
_____ Psychiatric Evaluation _____ Service Summary _____ Psychological Evaluation
_____ Lab Results _____ Medication Record _____ History and Physical
initial **Alcohol or other drug treatment records. Specify below and attach Notice prohibiting redisclosure**
initial Summary of assessment results and history (check this area if info from a substance abuse program will be shared.
initial Summary of treatment and service plan progress and compliance Attach Notice Prohibiting Redisclosure
_____ **Other (specify)** _____
initial **Records sent to DHHS from other providers and contained in the program record**

Initial if you are a contract agency requesting ITM and want to invite other contract agencies.

3. Reason this information is being shared To provide coordinated services. This will include team meetings with all agencies/individuals listed in Box 1, and continued communication between and with everyone listed in Box 1

4. This authorization is valid (*Check only one-not to exceed one year*)
☐ until _____(date) ☐ for 90 days ☐ until these conditions are met: _____

5. I understand I can revoke this authorization at any time by submitting a request in writing to DHHS program staff. The revocation will become effective on the date it is received by DHHS and does not apply to information that has already been used or disclosed through this authorization. DHHS may not condition treatment, payment, enrollment or eligibility for services/ benefits based on whether I sign this authorization, unless authorization is required to determine eligibility for services/benefits. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to federal or State privacy laws, this information may no longer be protected and could be disclosed. 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 redisclosed without my written consent or as permitted by the regulations.

See section 5 of Instructions attached for guidance on who must sign.

Signature of client **Date**

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

If signed by other authorized person, please describe authority to act on behalf of the client (*Please Print*)

Signature of DHHS staff member **Date**

NOTICE PROHIBITING REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Instructions for Completing the Authorization to Release/Receive Information Form

This authorization form must be signed by the client or authorized representative and DHHS staff when:

- The client or authorized reprsentative requests that DHHS release informaiton to an outside program, agency or individual.
- DHHS staff need to receive information about the client from an outside source to provide services.

Please PRINT all information except signature lines

[1]

- Use a separate form for each entity, unless the entities will be receiving from us or sending to us the same information for the same purpose. This is known as a "multi-party" consent form.
- Use one form if DHHS is to send information to and a separate form if DHHS is also to receive information from the same entity, unless it is the same information for the same purpose.
- Clients may authorize DHHS to discuss the specified information with the named entity, or to only discuss the specified information, without releasing all or part of the record.

Example: The client wants DHHS to send the diagnosis and service summary and to discuss this information with the recipient. Check the "send to" and "verbally discuss" boxes.

[2]

- Under federal law, the description of the information requested must be "specific and meaningful." If the release is initiated by DHHS, staff must include only the minimum necessary information needed to accomplish the purpose of the request.
- If the authorization includes the release of all or part of a medical record, State law mandates that the authorization applies only to a medical record developed by DHHS unless the client specifies in writing that this authorization includes health information received from another health care provider that is contained in the DHHS record and the provider has not prohibited redisclosure.

Example: The client has initialed the box authorizing release of the complete DHHS medical record and the box authorizing release of records received from other providers. Release the entire record, including those from other providers, except those stamped "not to be redisclcosed."

- If the authorization includes the release of all or part of an alcohol and substance abuse treatment record, under federal law the client must specifically authorize the disclosure of that information (even acknowledgement that the client applied for or was receiving such services.) A Notice Prohibiting Redisclosure must also be attached.

[3] If this release is initiated by DHHS, a clear description of the purpose of this request must be given. If this request is initiated by the client or authorized representative, the statement "at the request of the individual" is a sufficient description.

4] This authorization is valid for a period not to exceed one year except in the following instances:

- Cases of criminal justice referrals, in which case authorization shall be valid until 30 days following final disposition.
- Cases in which the patient/client is a resident of a nursing home, in which case the authorization is valid until revoked or for a time specified in the authorization.

[5]

- Minor/Medical Record: A Minor (under 18), not the parent, has the capacity to authorize the release of their medical record or information contained therein, if:
  - the minor is married and presents a marriage certificate; or
  - the minor is a parent and presents a birth certificate; or
  - the record or information sought pertains to treatment or advice about:
    * drug abuse *alcoholism *venereal disease *pregnancy or *contraception other than sterilization
    OR the record or information sought pertains to:
    * physical exam and treatment of injuries from an alleged rape or sexual offense; or
    * physical examination to obtain evidence of an alleged rape or sexual offense; or
    * initial medical screening and exam on or after admission into a detention center.
- Minor/Mental Health Record: Minors 16 years or older, not the parent, have the capacity to authorize the release of their mental health record or information contained therein.
- Minor/Parent Authorization: An individual signing for a release of information as a minor's parent for other than the above cited exclusions must present a birth certificate for the minor child. If a birth certificate is not immediately available a signed, witnessed statement certifying that he or she is the minor's parent and that he or she will produce the birth certificate by a given date, must be included in the record.
- Legal Guardian/Minor or Adult: The legal guardian of a minor or adult must present a court order assigning guardianship.
- Health Care Power of Attorney: The health care agent must present a written advance directive appointing the health care agent to make decisions. Certification from two physicians that the individual is incapable of making informed decisions must be presented, or certification from one physician if the individual is unconscious. Capacity to act for mental health purposes must be specifically designated.
- Informal Kinship Care: An individual claiming kinship care must present an affidavit that has been filed with the Maryland Department of Human Resources, Social Services Administration.