H-1

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Montgomery County Department of Health and Human Services

Program/Service Area _____

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:**

Agency/Individual: _____

Address: _____

_____

2. ***Initial*** ***all items covered by this release.*** ****Initial if you are a contract agency requesting the ITM and want to invite other contract agencies.***

_____ **Acknowledgment of receipt of services**

_____ **Complete program record (includes all items below)**

_____ Intake Assessment _____ Treatment Plan _____ Progress Notes _____ Diagnosis

_____ Psychiatric Evaluation _____ Service Summary _____ Psychological Evaluation

_____ Lab Results _____ Medication Record _____ History and Physical

_____ **Alcohol or other drug treatment records. Specify below and attach Notice prohibiting redisclosure**

_____ Summary of assessment results and history

_____ Summary of treatment and service plan progress and compliance

_____ **Other (specify)** _____

_____ ***Records sent to DHHS from other providers and contained in the program record.**

3. Reason this information is being shared _____

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.

_____ _____

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**