Authorization to Use/Disclose Health Care Information

CARROLL MENTAL HEALTH CARE
1643 Liberty Rd, Ste 204, Eldersburg, MD 21784
p:410-552-9004, f:410-552-9003

Patient Name: _____ **Birth date:** _____

I request and authorize _____
to release the health care information described below to:

Name: _____

Address: _____

City, State: _____ Zip Code: _____

Phone: _____ Fax: _____

Health care information provided during time frame: _____

Please initial to authorize specifically the use and/or disclosure of:

_____	Emergency Room / Urgent Care Records	_____	Admission Note	_____	Initial Psychiatric Evaluation
_____	Hospital Records (nursing and progress notes)	_____	Discharge Summary	_____	Medication History
_____	X-Ray / Laboratory Reports (specify):	_____	Clinical Summary	_____	Outpatient Progress Notes
_____	Consultation Report (specify):	_____	Psychological Test Report	_____	Verbal Discussion of Case
_____	Other (specify):				

Purpose(s) of this use/disclosure: (At the request of the individual, or) _____

_____

Authorization expires: _____

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to _____ (privacy officer or psychiatrist).

I understand that Dr. _____ (or name of facility) may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to CARROLL MENTAL HEALTH CARE from a third party. [If applicable].

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug alcohol treatment or use.

Signature: (patient or authorized representative) _____

Date: _____

Relationship/authority: (if signed by authorized representative) _____

I have received a copy of this signed authorization: (please initial) _____ yes _____ no