Integrative Therapeutic Family Services/ Mobile Crisis Stabilization Services

**Referral Form**

# Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_

MA# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This child is currently residing *(Check One):* With biological parent(s) With another family member

Foster Care Shelter Care Group Home RTC Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current caregiver of child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has custody of the child?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the legal guardian of the child?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who can sign releases of information for this child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the parent’s parental rights been terminated? Yes No

What is the present Permanency Plan for this youth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education:

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently Enrolled:  Yes  No Current School Grade:\_\_\_\_\_\_

Current Medical Information:

Name of Somatic Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child receiving mental health services?  Yes  No

Name of psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next scheduled appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has there been any known bed bug infestations in the home in the previous 2-3 months?  Yes  No

Please include any information that would be helpful including assessments, court orders, custody or guardianship papers, etc.

What brought this child/family to the attention of DSS?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Individual Authorization Releases are attached. Please complete the highlighted sections, obtain signatures, & return with the referral. **Blank Individual Authorization Releases provided below**. Please complete one for each service checked below and return signed documents with completed referral. A blank release is also provided for any other services we may not have included: Child’s therapist, Child’spsychiatrist , Child’s Primary Care Physician , Department of Social Services

Board of Education, Mental Health System’s Office, Child’s Lawyer, Foster Parents, All additional programs child may be working with (ex. Archway, DJS, Brooklane, etc.)

**For MHSO (CSA) use only:**

**ITFS:**

**MCSS:**

**INDIVIDUAL’S AUTHORIZATION**

**Purpose**: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual’s health information.

**Please type or print neatly; we are not able to process incomplete or illegible forms.**

**Check if this authorization is for psychotherapy notes.** If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S**): MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** Department of Social Services\_\_\_\_\_**ADDRESS** \_\_One Frederick St., Cumberland, MD 21502\_\_

**TELEPHONE NUMBER**: \_301-784-7000\_\_\_\_\_\_\_\_\_\_\_\_\_

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_X\_\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

Expiration: This authorization will expire (complete one):

On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact **MHSO (CSA)**. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.

**Section D: Signature**

**To the Individual – Please read the following.**

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INDIVIDUAL’S AUTHORIZATION**

**Purpose**: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual’s health information.

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**Check if this authorization is for psychotherapy notes.** If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S**): MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** \_Board of Education\_\_\_\_\_\_\_\_**ADDRESS** \_108 Washington St., Cumberland, MD 21502\_\_\_\_

**TELEPHONE NUMBER**: \_301-759-2000\_\_\_\_\_\_\_\_\_\_

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_\_X\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

Expiration: This authorization will expire (complete one):

On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact **MHSO (CSA)**. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.

**Section D: Signature**

**To the Individual – Please read the following.**

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(PRIMARY CARE PHYSICIAN) INDIVIDUAL’S AUTHORIZATION**

**Purpose**: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual’s health information.

**Please type or print neatly; we are not able to process incomplete or illegible forms.**

**Check if this authorization is for psychotherapy notes.** If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S**): MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE NUMBER**: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_X\_\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

Expiration: This authorization will expire (complete one):

On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact **MHSO (CSA)**. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.

**Section D: Signature**

**To the Individual – Please read the following.**

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(THERAPIST) INDIVIDUAL’S AUTHORIZATION**

**Purpose**: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual’s health information.

**Please type or print neatly; we are not able to process incomplete or illegible forms.**

**Check if this authorization is for psychotherapy notes.** If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S**): MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE NUMBER**: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_X\_\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

Expiration: This authorization will expire (complete one):

On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

Purpose of the use and/or disclosure being authorized):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact **MHSO (CSA)**. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.

**Section D: Signature**

**To the Individual – Please read the following.**

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**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(PSYCHIATRIST) INDIVIDUAL’S AUTHORIZATION**

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**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S**): MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE NUMBER**: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_X\_\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

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On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

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**Section D: Signature**

**To the Individual – Please read the following.**

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**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(LAWYER) INDIVIDUAL’S AUTHORIZATION**

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**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S**): MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE NUMBER**: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_X\_\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

Expiration: This authorization will expire (complete one):

On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

Purpose of the use and/or disclosure being authorized):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact **MHSO (CSA)**. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.

**Section D: Signature**

**To the Individual – Please read the following.**

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(FOSTER PARENT) INDIVIDUAL’S AUTHORIZATION**

**Purpose**: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual’s health information.

**Please type or print neatly; we are not able to process incomplete or illegible forms.**

**Check if this authorization is for psychotherapy notes.** If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S**): MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** Department of Social Service Foster Parents **ADDRESS** One Frederick St. Cumberland, MD 21502

**TELEPHONE NUMBER**: \_ 301-784-7000

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_X\_\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

Expiration: This authorization will expire (complete one):

On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

Purpose of the use and/or disclosure being authorized):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact **MHSO (CSA)**. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.

**Section D: Signature**

**To the Individual – Please read the following.**

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(ARCHWAY or OTHER PROGRAMS) INDIVIDUAL’S AUTHORIZATION**

**Purpose**: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual’s health information.

**Please type or print neatly; we are not able to process incomplete or illegible forms.**

**Check if this authorization is for psychotherapy notes.** If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S**): MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE NUMBER**: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_\_X\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

Expiration: This authorization will expire (complete one):

On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

Purpose of the use and/or disclosure being authorized):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact **MHSO (CSA)**. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.

**Section D: Signature**

**To the Individual – Please read the following.**

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(BROOKLANE or other HOSPITAL) INDIVIDUAL’S AUTHORIZATION**

**Purpose**: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual’s health information.

**Please type or print neatly; we are not able to process incomplete or illegible forms.**

**Check if this authorization is for psychotherapy notes.** If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S**): MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE NUMBER**: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_\_X\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

Expiration: This authorization will expire (complete one):

On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

Purpose of the use and/or disclosure being authorized):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact **MHSO (CSA)**. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.

**Section D: Signature**

**To the Individual – Please read the following.**

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(BLANK) INDIVIDUAL’S AUTHORIZATION**

**Purpose**: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual’s health information.

**Please type or print neatly; we are not able to process incomplete or illegible forms.**

**Check if this authorization is for psychotherapy notes.** If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

**Section A: Individual’s Health Information authorized for Use and Disclosure.**

**Last Name:** **First Name**: **\_\_\_ MI**:\_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**City:**  **State: \_ Zip:** \_ \_

**Phone: (home) (work) \_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_DOB: \_\_ \_\_\_\_\_**

**Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.** To share, exchange, obtain, disclose information.

.**The purpose of the disclosure (optional):** Continuation and continuity of care

**Who is authorized to Receive/Disclose and Use your health information:**

**DHMH PROGRAM NAME(S):** MHSO (CSA)

**ADDRESS:** P.O. Box 1745 Cumberland, MD 21502

**TELEPHONE NUMBER**: (301) 759-5070

**Who is authorized to Receive/Disclose and Use your health information:**

**NAME(S)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEPHONE NUMBER**: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the information which the program has includes records or information from another entity, I **\_ \_** do or \_X\_\_\_ do not wish to have that information released under this authorization.

**Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.)**

Expiration: This authorization will expire (complete one):

On \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the

Purpose of the use and/or disclosure being authorized):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact **MHSO (CSA)**. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.

**Section D: Signature**

**To the Individual – Please read the following.**

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

**Personal Representative’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_