



UPPER BAY COUNSELING AND SUPPORT SERVICES, INC.

Authorization for Release of Information (To be Valid, this form must be filled out completely.)

Client's Name _____ AKA: _____

Date of Birth _____ Social Security Number _____

I, _____ do hereby authorize Upper Bay Counseling & Support Services, Inc.

Please initial appropriate line(s)

_____ To Release Information To: _____ To Obtain Information From:
_____ Verbal Communication _____ Ongoing Interagency Communication

(Name of Person) (Organization)

(Street Address) (City) (State) (Zip Code)

I understand that this information includes treatment for behavioral, mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, infectious/contagious disease including, but not limited to, HIV/AIDS or tests for HIV or AIDS, and developmental disabilities.

Specific information not to be disclosed: _____

The specific type of information to be disclosed includes: (Initial all items to be released)

_____ Discharge Summary _____ Initial Assessment _____ PRP Contact Notes: Date(s) _____
_____ Physical Exam & History _____ Medication Orders _____ School/Educational Records
_____ Psychological Testing _____ Aftercare Plan _____ Lab/Testing Report
_____ Referral: _____
_____ Individual Treatment Plan: Date(s) _____ Individual Rehab Plan: Date(s) _____
_____ Psychiatric Progress Note(s): Date(s) _____
_____ Other (Be Specific): _____

The purpose of this disclosure to/for: (initial all that apply)

_____ Evaluation & Treatment Planning _____ Coordination of Services
_____ Assist with Legal Issues _____ Disability Claim _____ Job Recommendations
_____ Inform Family Member _____ Inform Employer _____ Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules.

I understand that I may revoke this authorization in writing at any time. Otherwise this authorization is valid for until one year after date of signature or _____
(Specification of date/event, or condition upon which consent expires)

Date: _____ Signature: _____

Witness: _____
(If Signed by Legal Representative, Relationship to Patient)

Any individual or agency receiving this information is prohibited from making any further disclosure of this information without the specific written consent of the person to whom it pertains (or that of their legal representative), except in those cases consistent with Maryland State or Federal Law, statute, or regulation whereby this information must be produced or otherwise examined.

- Booth Street Office (410) 996-5104 Fax: (410) 996-5197
- Route 40 Office (410) 620-7161 Fax: (410) 620-7168
- Havre de Grace Office (410) 939-8744 Fax: (410) 939-8748
- Delaware Adoption & Counseling (302) 764-1890 Fax: (302) 764-1893
Felton, DE (302) 335-1690 Fax: (302) 335-1691