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 one year from the 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 the their legal representative), except in those cases consistent with Maryland State or Federal Law, statute, or regulation whereby this information must be produced or other wise examined.

Booth Street Office	Route 40 Office	Havre de Grace Office
(410) 996-5104	(410) 620-7161	(410) 939-8744
Fax: (410) 996-5197	Fax: (410) 620-7168	Fax: (410) 939-8748

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