ST. MARY'S COLLEGE OF MARYLAND

COUNSELING & HEALTH SERVICES
18952 E. FISHER ROAD
ST. MARY'S CITY, MD 20686
TEL.: 240-895-4289 – FAX: 240-895-4937

AUTHORIZATION FOR RELEASE OF MEDICAL AND MENTAL HEALTH INFORMATION

Name_____ Perm/ID #_____ Date of Birth __/__/____ Phone_____

Address_____ City_____ State_____ Zip code_____

I authorize:
(Person or facility which has medical and mental health information)
Name_____
Address:_____
Phone:_____
Fax:_____

To release medical and mental health information to:
(Person or facility to receive health information)
Name_____
Address:_____
Phone:_____
Fax:_____

Type of disclosure: ☐ Verbal Information ☐ Copies of records

Please specify the information you authorize to be released:

- ☐ *Mental health information (Subject to Maryland's Confidentiality of Medical Records Act, codified at Health-General § 4-301 et seq.).*
- ☐ *Medical (This may include but is not limited to drug/alcohol and mental health information documented by a primary care practitioner)*
- ☐ *Drug and alcohol abuse, diagnosis or treatment information subject to federal law (42 C.F.R. §§2.34 and 2.35).*
- ☐ *HIV/AIDS test results (Health and Safety Code §120980(g)).*

Type(s) of information, if not specified above (e.g. Summary Report)_____

Specify date(s) of treatment, time period or condition:_____

Limitations, if any, upon disclosure:_____

The purpose of this release is:
☐ At the request of the client/patient/patient representative ☐ Other (state reason) _____

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this Authorization expires on _____.
If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____
Client/Patient/Patient Representative Signature

_____
Relationship to Client/ Patient

_____
Date

NOTICE: SMCM and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS: This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) solely to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your client/patient representative, and delivered to SMCM The revocation will take effect when SMCM receives it, except to the extent SMCM or others have already relied on it. You are entitled to receive a copy of this Authorization.