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.

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) _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.

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: _____

(PSYCHIATRIST) 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: _____

(LAWYER) 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: _____

(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.

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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) 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.

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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: _____

(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.

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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: _____

(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: _____