PO Box 10405 Rockville, MD 20849 888-933-1112
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AUTHORIZATION FOR REQUEST/RELEASE OF CONFIDENTIAL INFORMATION

CLIENT INFORMATION

Client Name ______________________________ **DOB** __________________**SSN** _______________________________

Address and phone # ____

REQUEST/RELEASE OF INFORMATION

I hereby authorize:
_(local hospital)_____________________________________ _(local psyc hospital)______________________________________
_(Pharmacy)____ _(Internist)____
_(Psychiatrist)______________________________________ _(Therapist)____
_(Family)____ ____
____ ____
to release/request information from the medical records of the above-named patient for the purpose of ___Continuity of Care___.
To: *HELP IN THE HOME, LLC PO BOX 10405 Rockville, MD 20849* 888-933-1112*Fax: 888-611-3340*
For treatment dates: ______________continuous____ of requested facility.

TYPE OF INFORMATION REQUESTED/RELEASED:

____ Discharge Summary ____ Admission Note ____ History & Physical ____ Psychosocial History ____ Labs

____ Consultation ____ Medical Tests ____ Contact with family or outside treatment team ____ Other ______________

*** I understand that I may specify a date for the expiration of this authorization, but that it shall expire by law, without my express revocation, one year from the date written below, unless the client is a resident of a nursing home. This authorization complies with HIPAA. A photocopy of this authorization may be used in lieu of the original. This authorization covers only treatment for the dates requested above (this applies only when requesting records from an outside facility). I understand that I have the right to refuse to sign this Authorization for Release of Confidential Information and that I am may revoke this Authorization for Release of Confidential Information at anytime in writing.*

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein described. I understand that this authorization may be revoked by me at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the program director. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I acknowledge that the material l authorized for release may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that health information used to disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2. This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for the Release of Confidential Information."

____________________ ____

Date Signature of Client

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.