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 (last four digits) XXX-XX-**_____

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

Please initial all appropriate line(s)

_____ To Release Information To: **_____ To Obtain Information From:** **_____ Ongoing Communication**

_____

(Name of Person) **(Organization)**

_____

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

Method of Disclosure: **____ Verbal Communication** **_____ Photo Copy** **___ Electronic copy via CD**

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 (Diagnostic Impression & Psychosocial Assessment)

_____ Physical Exam & History _____ Medication Orders _____ School/Educational Records

_____ Psychological Testing _____ Aftercare Plan _____ Lab/Testing Report

_____ Referral: _____

_____ Individual Treatment & Rehab Plan (includes complete diagnosis) Dates:_____

_____ Prescriber's 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 _____ At My Request

_____ 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
(410) 996-5104
Fax: (410) 392-8048

Route 40 Office
(410) 620-7161
Fax: (410) 620-7168

Havre de Grace Office
(410) 939-8744
Fax: (410) 939-8748