Associated Behavioral Health Services
939 Elkridge Landing Road Suite 350
Linthicum, MD 21090
P:443-354-8903 F:443-410-0643

Patient Name:____ **Date of Birth**:__________________

Consent to Release/Receive Confidential Health Information:

I, (Adult Client/Parents Name) _________________________________ , hereby authorize Associated Behavioral Health Services:

- ☐ To Release
- ☐ To Receive to/from the following person or agency listed below.

This information is to be in the form of:

- ☐ Written records
- ☐ Verbal communication

This information is requested for the purposes of:

- ☐ Treatment planning
- ☐ (re) evaluation
- ☐ Case management
- ☐ Other: Please specify:____

I understand that my records are protected by applicable federal and state laws/regulations and cannot be released without my written consent unless otherwise provided for by law. See 42 CFR Part 2; 42 U.S.C. §§290dd-22; Annotated Code of Maryland, Health-General, §§4-302, 4-306, et seq. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.
I understand that this consent for the release of information will be in effect beginning: _______________ and will expire on: _____________ (not greater than 1 year), or earlier under the following circumstances: I understand that I may revoke this consent at any time (except to the extent that action has been taken in reliance on it) by written request (or by verbal request if I am physically unable to provide a signature). I understand that generally disclosure of medical information will not diminish the condition my treatment on whether I sign a consent form, but that in certain very limited circumstances I may be denied treatment if I do not sign a consent form. I understand that there is the potential for information disclosed pursuant to this consent to be subject to re- disclosure by the recipient and no longer be protected under HIPAA.

I am only authorizing the release of the information/reports as specified below:

- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Neuropsychological Evaluation
- ☐ Social Work Report
- ☐ Court Records
- ☐ Lab Work
- ☐ Other: __________
- ☐ Discharge Summary
- ☐ Neurological Evaluation
- ☐ Assessment/Evaluation Summary
- ☐ Medical History/Evaluation
- ☐ Treatment/Aftercare Plan

Name, Address, Phone, Fax of previous Provider:

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I understand that I am consenting to release this confidential information to be used only in a professional manner by the person/organization to which this information is being forwarded.
Client Signature:____ Date:____________________
Signature of Witness: ____ Date: ____________________

Signature of Parent/Guardian:_____________________________________ Date:____________________
Signature of Witness:____ Date:____________________

Copy offered to Client? (Check one) Yes No