AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please fax completed form to: 1(443) 583-4830

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name: | | | |  | | | Date of Birth: |  | | |
| Previous Name: | | | |  | | | Identification #: | |  | |
| I request and authorize | | | | | | HMC HealthWorks | | | | to | |
| release Behavioral Healthcare information of the patient named above to: | | | | | | | | | | |
|  | Name: | |  | | | | | | | |
|  | Address: | | | |  | | | | | |
| **This request and authorization applies to:**  🞎 Information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§2.34 and 2.35)  🞎 Information pertaining to mental health diagnosis or treatment (California Welfare and Institutions Code §§5328, *et. seq.*) | | | | | | | | | | |
| 🞎 All healthcare information | | | | | | | | | | |
| 🞎 Other: | |  | | | | | | | | |
| **Notice to Authorizing Party:** | | | | | | | | | | |
| * This authorization is effective for the above requested and authorized healthcare information only. You may ask for and receive a copy of this authorization form. * This authorization will expire one (1) year after the date on which it is signed. Additionally, you may revoke this authorization at any time by submitting a request to this provider. Your revocation will be honored except to the extent that it has been acted on in good faith while in force. * You have the right to inspect the information you are authorizing to be released. * The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. * You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility or benefits. | | | | | | | | | | |

Signature of Patient or Person Authorized to Sign for Patient Date

Printed Name

If not signed by the patient, indicate relationship of authorizing person to patient:

□ Parent or guardian of minor child

□ Guardian or conservator of conserved patient

□ Beneficiary or personal Representative of a deceased individual