



Authorization for Release of Confidential Information

(To be Valid, this form must be filled out completely.)

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 to receive treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

Client's Name: _____ Date of Birth: _____

Address: _____

Social Security Number (Last Four): xxx-xx- _____

I hereby authorize Advantage Psychiatric Services, LLC:

To Release Information To To Obtain Information from

Name: _____ Address: _____

Method: USPS Mail

Fax: _____

Encrypted E-Mail _____

Verbal Communication

Photo Copy

To release health information that 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 specific for HIV or AIDS, and developmental disabilities.

Specific information NOT to be disclosed: _____

For Treatment date(s): _____ or Any/all previous treatment dates at your facility.

Type of information requested: (Check all that apply)

Advantage Psychiatric Services, LLC reserves the right to redact or withhold portions of the medical record that are deemed unnecessary, irrelevant, or potentially harmful to the client or others. Advantage Psychiatric Services, LLC reserves the right to deny the release of records if the request does not meet legal or ethical standards. Medical records are the property of Advantage Psychiatric Services, LLC.

Discharge Summary Medication(s)

Admission Summary Referral

Biopsychosocial Assessment Summary of Services

Treatment Plans Other (Be Specific): _____

The purpose of this disclosure to/for: (Check all that apply)

Evaluation and Treatment Planning Coordination of Services

At My Request Disability Claim

Inform Family Member Assist with Legal Issues

Job Recommendation Other _____

I understand that I may revoke this authorization verbally and then follow up in writing at any time. Otherwise, this authorization is valid for one year from date of signature or discharge from Advantage Psychiatric Services, LLC – or- _____

(Specification of date, event, or condition upon which consent expires) (whichever comes first).

Date: _____ Signature: _____

Witness: _____ Signature: _____

(Printed Name)

(If Signed by Legal Representative, Relationship to Patient)

Any individual or agency receiving this information is prohibited from making any further disclosures of this information without the specific written consent of the person to whom it pertains (or that of their legal representative), except in those cases consistent with Maryland State or Federal Law, statute, or regulation whereby this information must be produced.