UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, _____, am signing this form for

FULL PRINTED NAME OF AUTHORIZING PERSON OR PERSONS

_____

FULL PRINTED NAME OF INDIVIDUAL

_____

INDIVIDUAL'S ADDRESS *INDIVIDUAL'S BIRTH DATE* *INDIVIDUAL'S SSN*

My relationship to the individual is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian
☐ Other Legally Authorized Representative

I want the following confidential information about the individual to be exchanged:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed, Planned, and/or Received	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records
☐	☐	Substance Abuse Records*				☐	☐	All of the Above

Other Information (write in): _____

I want the following entities to be able to use and exchange this information among themselves: Participants in the Child and Family Team meeting, Frederick County CSA, Frederick County CPMT and members of the Frederick County Family Assessment and Planning Team and/or _____

_____

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination
☐ Other: _____

I want this information to be shared by the following means: *(check all that apply)*
☒ Written Information ☒ In Meetings or By Phone ☒ Computerized Data ☒ Fax

I want to share additional information received after this authorization is signed: ☒ Yes ☐ No

This authorization is effective: _____
(DATE)

This authorization is good until: ☐ My service case is closed. ☐ Other: _____

For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his authorized representative specifies an expiration date, event or condition that will occur prior to one year from the date of signature.

I can withdraw this authorization at any time by telling the referring agency. The listed agencies must stop sharing information after they know my authorization has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as valid authorization to share information. **If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.** However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature: _____ Date: _____
PATIENT/CLIENT-Required for youth 14 yrs and older with Substance Abuse Issues

Signature(s): _____ Date: _____
AUTHORIZING PERSON OR PERSONS

Person Explaining Form: _____
(Name) *(Address)* *(Phone Number)*

Witness *(If Required)*: _____
(Signature) *(Address)* *(Phone Number)*

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM:** **This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2.)** **The Federal rules prohibit you from making any further disclosure of this information unless further disclosure 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.