421 FALLSWAY
BALTIMORE, MARYLAND 21202
410-837-5533

HEALTH CARE FOR THE HOMELESS (PEDS)
AUTHORIZATION TO RELEASE/REQUEST PROTECTED HEALTH INFORMATION

Name	SSN#	Date of Birth

I, Authorize: _____ **To Release to**: _____

_____ _____

_____ _____

This information is to be limited to the following: Date(s) of service: _____

- ❒ History and Physical
- ❒ Medical Progress Note
- ❒ Nursing Notes
- ❒ Medication Sheet
- ❒ Labs/X-Rays/Consultations
- ❒ Mental Health Records including psychotherapy notes
- ❒ Addictions Records
- ❒ Social Service Records
- ❒ Other (please specify) _____
- ❒ The information designated above is intended to include information received from a third party provided the third party has not prohibited re-disclosure.

Purpose of Request:
- ❒ At the request of the individual
- ❒ Legal
- ❒ Sharing with other Health Care Providers as needed
- ❒ Other (please specify below)

_____

Release of Special Information: (circle appropriate response and initial if applicable)

I DO / DO NOT authorize to release information pertaining to psychiatric, drug/ or alcohol abuse, sexually transmitted diseases. **Initials:**_____

I DO / DO NOT authorize to release information pertaining to HIV/AIDS related testing, diagnosis and/or treatment. **Initials:**_____

Individual rights: I understand the following:
- This request will be processed within 30 days.
- I need not sign this form to ensure healthcare treatment or payment.
- I have the right to revoke this authorization at any time.
- If I revoke this authorization I must do so in writing to the attention of the Medical Record Department at HCH.
- My right to revoke does not apply to information that has already been released on the basis of this authorization.
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal rule on privacy.
- This authorization will expire in 180 days unless revoked or another date otherwise specified.

(Parent/Guardian Signature)	(Witness Signature)	Date