WASHINGTON COUNTY HEALTH DEPARTMENT

Division of Behavioral Health Services
925 North Burhans Blvd. • Hagerstown, MD 21742
240-313-3310 Voice • 240-313-3391 TDD • 240-313-3239

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, _____, _____
(Name of Patient) (DOB) (PRF)

Authorize Washington County Health Department Division of Behavioral Health Services, to

DISCLOSE TO/OBTAIN FROM _____

_____
(Name of Person or Organization)

the following: DEMOGRAPHIC AND IDENTIFYING INFORMATION ALL ASSESSMENTS AND EVALUATIONS, TREATMENT RECOMMENDATIONS, PARTICIPATION IN TREATMENT, TREATMENT REFERRALS FOR OTHER SERVICES, PROGRESS, ATTENDANCE, DISCHARGE INFORMATION/SUMMARY, URINALYSIS AND BREATHALYZER RESULTS
(Nature of Information)
through verbal communication, email, fax, text message, telephone contact and/or written communication for the purpose of coordination of services.

I understand that my records are protected under the Federal regulations governing Confidentiality of Drug and Alcohol Abuse Patient Records, 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R., Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

Specification of the date, event or condition upon which this consent expires:

This consent expires one year from the date of signature listed below unless otherwise specified:

_____

I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I was offered a copy of this release. I chose to ___accept ___decline

_____ _____
Signature of Patient / Parent / Guardian / or Authorized Representative Date

_____
Signature of Witness

Describe authority to sign on behalf of patient (if applicable): _____

I chose to revoke my consent. Date: _____ Time: _____ Patient Initials: _____

Dev.: 5/98; Rev.: 1/2020