Release of Information

CLIENT: ______________________________ **DOB:** ____________________

CLIENT ADDRESS: ____

CLIENT PHONE: ____

SOCIAL SECURITY NUMBER: ______________________

The Caroline County Medical Adult Day Care (CMADC) has my permission to RELEASE and OBTAIN protected medical and Behavioral Health information including: History: Physical, X-Rays, medication list, prognosis, diagnosis, activity restrictions, allergies, diet, PPD reports, and discharge summaries to and from the following agencies and/or providers and give permission for ongoing communication concerning information from following agencies and/or providers:

Hospital: ____

Nursing Home: _______________________________________

Physicians: ____

Pharmacy: ____

Home Health Agency:__________________________________

Mental Health Provider:________________________________

Channel Marker: ______________________________________

AERS, MAPC Provider Program: __________________________

Tele-Psychiatry: ______________________________________

Other: ____

Medical Adult Day Care Center: Denton | 403 S. 7th Street, Denton, Maryland 21629 | (p) 410-479-8065
HEALTH.MARYLAND.GOV/CAROLINECOUNTY
Scott LeRoy, Caroline County Health Officer

Client Name: ____

I give permission to take my photograph for use as a photo ID, advertisement, and organized study for the program. ____________(Initial for permission)

Client/Legal Representative: ______________________ Date**:** __________

MADC Representative: __________________________ Date**:** __________

The information obtained above is valid for one year from the date of signature and needs yearly renewal.