The Caroline County Health Department

Health Officer, Scott T. LeRoy, MPH, MS Deputy, Attillio J. Zarrella, Th.D

INDIVIDUAL'S AUTHORIZATION

Purpose: This form is used to confirm the direction of an individual to authorize the Caroline County Health Department to request, to use, or to disclose the individual's health information.

Please type or print neatly; we are not able to process incomplete or illegible forms.

☐ **Check if this authorization for Psychotherapy notes.**

If this authorization is for Psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

SECTION A : Individual's Health Information authorized for Use and Disclosure.

Last Name: _____ First Name: _____MI:_____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Phone (Home):_____ (Work):_____ Date of Birth: ____ / ____ / ____

SECTION B : The Use and / or Disclosure being authorized.

Provide a detailed description of the health information you are authorizing us to use and/or disclose.

The purpose of the Disclosure (Optional): _____

Who is authorized to ☐ Disclose / ☐ Receive and Use your health information:

NAME (S): Developmental Disabilities Program (Caroline County Health Department)

ADDRESS: 403 S. 7th Street Denton, MD 21629

PHONE: 410-479-8075 FAX : 410-479-5383

Who is authorized to ☐ Disclose / ☐ Receive and Use your health information:

NAME (S): _____

ADDRESS: _____

TELEPHONE NUMBER: _____ FAX : _____

If the information which the program has includes records or information from another entity, I ___ do or ____do not wish to have that information released under this authorization.

SECTION C: Expiration and Revocation

Expiration: This authorization will expire (complete one):

☐ On _____/ _____/ _____ (MM/DD/YYYY) **~ OR ~**

☐ On occurrence of the following event*: _____

**(This must relate to the individual or to the purpose of the use and/or disclosure being authorized)*

Right to Revoke: *I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact* ***Caroline County Health Department****. I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.*

SECTION D: Signature

To the individual: Please read the following:

- *I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is voluntary.*
- *I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws.*
- *I have had full opportunity to read and consider the contents of the authorization, and I confirm that the contents are consistent with my intent.*

Signature: _____ *Date:* _____

If a ***personal representative*** *is making this request, please attach a copy of any document granting legal authority and complete the following:*

*Personal Representative's Signature:*_____

PRINTED Name: _____

Relationship to the Individual: _____

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