

Tri County Alliance for the Homeless

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Homeless Clients' Personal Identifying Information:

Name: _____ Birth Date: //

SSN: _____ Phone _____ Sex: Race:

Present Address:

Former Name (if applicable): _____

I authorize the following to obtain my personal information:

Name	Address	Phone Number
Tri-County Alliance for the Homeless Program (TCAH) / HMIS		443-523-1810

I request and authorize that the following personal information be provided:

- Mental Health
- Substance Abuse Treatment Information
- Communicable Disease information
- Disability Information
- X-Ray Reports
- Discharge Summary
- Shelter Stay
- Hospitalizations
- Other Health Care Information (Specify) _____
- Other Personal (e.g. income, financial) information (Specify) _____

Except for the following which expressly may NOT be disclosed (If none, write "NONE"):

If the information which a program has includes records or information from another entity, I DO or DO NOT wish to have that information released under this authorization. No service will be withheld if you do not authorize release of information attained by a program from another agency.

Conditions for Exchange of Authorized Information

Expiration: This authorization will expire one year from date below unless revoked in writing:
DATE //

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice in good faith. (CRIMINAL JUSTICE SYSTEM REFERRALS – RULES: “Revocation of consent” An individual whose release from confinement, probation, or parole is conditioned upon his participation in a treatment program may not revoke a consent given by him in accordance with paragraph (a) of this section until there has been a formal and effective termination or revocation of such release from confinement, probation or parole.” FEDERAL REGISTER, VOL 40, No 127, TUESDAY, July 1, 1975.)

USE SPACE BELOW ONLY IF CLIENT REVOKES CONSENT

//
Date Consent Revoked by Client

Signature of Client

CONFIDENTIALITY: If the request for information concerns a person's treatment of alcohol or drug abuse, the confidentiality of this information is protected by federal law: (42CFR Part 2) which prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose.

REDISCLASURE: Any individual or agency receiving Tri County Alliance for the Homeless (TCAH) client information is prohibited from making further disclosure of the medical record based on this authorization. This is prohibited as provided by the annotated Code of Maryland 4-303 (b) (5) (ii).

PHOTOSTAT/FACSIMILE: A Photostat or facsimile of this authorization is considered as effective and valid as the original.

Signature of Client

Date

Signature of Guardian or Legal Representative
Relationship to Client: _____
(Attach copy of document granting legal authority)

Date

Signature of Witness

Date

Signature of Counselor (if applicable)

Date