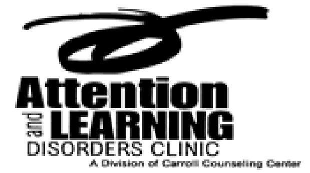

1380 Progress Way, Suite101 Eldersburg,MD 21784 PH: 410-549-5181 FAX: 410-549-5182

Authorization to Share Medical Information

Your Right to Medical Information Confidentiality

HIPAA is an acronym that stands for Health Insurance Portability and Accountability Act that was made into law in 1996. By law, if you are 18 years or older, you have the right to strict confidentiality regarding your visits at Carroll Counseling Center. In order to release any information, including the *date or nature of your visit, diagnosis, treatment plan, progress, and/or medication history*, Carroll Counseling Center must have your signed consent and specific directions about what information you are consenting to be released. Without written consent, Carroll Counseling Center cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, doctors, faculty, staff, or coach.

Choose 1 of the following options:

This authorization will expire: 1. _______________ (Specific date) 2. ________________ (Specific amount of time)
3. ____ (Occurrence of specific event related to the patient)

You have the right to revoke this authorization in writing at any time. This will be effective when Carroll Counseling Center receives your written revocation.

A copy of this authorization will be kept in your Carroll Counseling Center health record. The information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of this disclosure, no longer be protected to the same extent as this information was protected by law while solely in the possession of Carroll Counseling Center .

Patient Name: ____ Date of Birth: ____________________

FOR THE PURPOSE OF COORDINATING CARE, I AUTHORIZE

Provider (s) Name: ____
And/or Carroll Counseling Center to release or receive clinical information

In signing this authorization to release my protected health information, I acknowledge that I have read and understand my rights to medical information confidentiality.

Please indicate the information you authorize for release to the party named below:

( ) Any applicable mental health/substance abuse information including prescriptions and medication
( ) Only Medical Records during the period from ________________________ to ________________________
( ) Billing and Scheduling Information ONLY
( ) Other ____

This information above can be discussed with the following individuals ONLY:

____ Relationship _____________________________
____ Relationship _____________________________

Patient Signature ____ Date __________________________

Patient Representative _______________________________________ Relationship ____________________________