AUTHORIZATION FOR RELEASE OF INFORMATION

Instructions: Fill out this form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Client Name: _____ Date of Birth: _____

Current Address: _____

Phone/Cell Number: _____ Fax Number: _____

Previous Names: _____

RELEASE OF INFORMATION ☐ To ☐ From (check all that apply)

JSSA CONTACT INFORMATION

Attention to: _____

Address: _____

Phone/Fax: _____

EXTERNAL CONTACT INFORMATION

Name/Facility: _____

Address: _____

Phone/Fax: _____

I AM REQUESTING RECORDS AND/OR DISCLOSURE FOR THE FOLLOWING DATES: From: _____ To: _____

Only information obtained during the date range provided above will be disclosed.

PURPOSE OF DISCLOSURE: (check all that apply)

- ☐ Coordination of Care
- ☐ Transfer of Care/New Provider
- ☐ Guardianship Process
- ☐ Insurance/Billing/TPO
- ☐ Personal Records
- ☐ Legal/Court Hearing
- ☐ IEP/School
- ☐ Other: _____
- ☐ Disability Determination
- ☐ Confirmation of Services
- ☐ Workers Compensation

INFORMATION TO BE RELEASED: (check all that apply) Instructions: Items listed below with an * are **NOT** included in "All Records". If the items with an * are being requested, please specifically check these boxes.

- ☐ Clinical/Mental Health Progress Notes
- ☐ Prescription Record
- ☐ Intake/Closing Summary
- ☐ Employment Information
- ☐ Third Party Documentation*
- ☐ Substance Abuse and/or Alcohol Treatment Records*
- ☐ Psychiatric Progress Notes
- ☐ Diagnosis
- ☐ Treatment Plan/Summary
- ☐ Letter/Summary of Services*
- ☐ Medical/Dental Information
- ☐ Sexual Abuse/Assault Counseling Records*
- ☐ Case Management Progress Notes
- ☐ Psychological Eval/Assessment
- ☐ Billing/Financial Records*
- ☐ Completion of External Form*
- ☐ HIV/AIDS Information* _____ signer must initial
- ☐ All Records Please see instructions above.
- ☐ Other: _____

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FORMAT OF RECORDS TO BE RELEASED: (check all that apply)

☐ Paper/Hard Copy ☐ Electronic/Email* _____
email address required

☐ Verbal ☐ Other: _____

*Email address must be verified before any information can be emailed. All information sent via email will go through our secure email system.

FEES*: Fees are authorized annually by state law. Fee must be paid before records can be released. Record fees will be billed as follows:

Clients and Service Providers:

Paper Copies: Maryland: 76¢/page
Virigina: 50¢/page for first 50 pages, 25¢/page at 51 or more pages
Both: Copies totalling under 20 pages are free

Electronic Copies: Cost of Labor: $40/hr

* *Cash or credit only*

* *Some exceptions do apply; case by case basis*

Attorneys/Insurance Companies/Other: Service Fee: $22.88 (Maryland) or $10.00 (Virginia) in addition to costs stated above

MINOR CONSENT: Please review the information carefully. *Documentation of legal authority must be included with this request or it cannot be fulfilled.
*if applicable

- MD A minor who is 16 years old or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic [Md. Code Ann., Health-Gen. II § 20-104(a)].
- VA A minor who is 14 years old or older is "deemed an adult for the purpose of consenting to...medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance;" and the minor is "also deemed an adult for the purposes of accessing or authorizing disclosure" of those records [Virginia §54.1-2969, E and 12 VAC 35-115-90].

LEGAL AUTHORITY: Please review the information carefully. If information is missing the request may not be processed.
*if applicable

- If the client lacks capacity to sign, a legally authorized person may sign and date the form.

» » » Please indicate your legal authority and **include documentation** of your relationship:

☐ Power of Attorney/Health Care Proxy ☐ Legal Guardian/Conservator ☐ Other, specify _____

JSSA, employees, volunteers, and agents have a duty to maintain confidentiality of any protected health information disclosed to them pursuant to this authorization. The client or authorized person may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, by providing written notice to JSSA's Compliance Officer. Unless otherwise noted below, this authorization will expire 12 months from the date of consent. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and/or state confidentiality laws, including HIPAA. JSSA may not condition treatment, payment, enrollment, or eligibility for services on whether the client signs this authorization. The client has a right to a signed copy of this authorization.

Consent is granted: (check only one)

☐ One-Time ☐ One-Year ☐ Other, specify _____
Cannot exceed 1 year

Signature of Client or Authorized Representative: _____ Date Signed: _____

Printed Name of Person Signing (if not the client): _____ Relationship to Client: _____

*Documentation of legal authority must be included with this request or it cannot be fulfilled.

Office Use Only _____

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