UNIVERSITY of MARYLAND CHILDREN'S HOSPITAL

University of Maryland Care Clinic
AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION

I hereby authorize the University of Maryland's Care Clinic to obtain/release information as indicated below.

Patient Information:

Last Name First Name Middle Initial

Date of Birth Telephone #

Release/Obtain Information to/from:

Name

Address City State Zip

Phone # Fax #

☐ *I request the Care Clinic release the following information/records covering the time period of _____ to _____ to the entity indicated above (please check all that apply):*

( ) Phone Consultation
( ) Comprehensive Evaluation
( ) Mental Health Treatment History/Progress
( ) Other _____
( ) Psychological Evaluation(s)
( ) Psychiatric Evaluation(s)
( ) Discharge Summary

☐ *I request the Care Clinic obtain the following information/records covering the time period of _____ to _____ from the entity indicated above (please check all that apply):*

( ) Phone Consultation
( ) Comprehensive Evaluation
( ) Mental Health Treatment History/Progress
( ) School Reports Records
( ) Medical/Medication History/Exam/Lab Results
( ) Psychological Evaluation(s)
( ) Psychiatric Evaluation(s)
( ) Discharge Summary
( ) Social Agency Report
( ) Other _____

✓ I understand this authorization shall expire in one year from the date noted below and can be revoked in writing at any time as provided in the Care Clinic's Notice of Information Privacy Practices. Such a revocation will not cover disclosures made previously in reliance on this authorization.

✓ I understand that by signing this form, I am disclosing my status as a current or prior Care Clinic client (or having a connection to a current/prior client) to the agencies that information is being requested from and/or given to.

✓ The Care Clinic, its employees, officers, and medical staff are released from legal responsibility or liability for the release of the information in accordance with this authorization.

✓ I understand that the person/company receiving this information may not be subject to laws on confidentiality of medical information and may re-disclose it.

Signature of Client Date Signature of Parent/Guardian, if applicable Date

If not signed by Patient; authority to act for minor or incompetent patient:
( ) Parent ( ) Guardian ( ) Power of Attorney ( ) Closest Family Member consenting for patient's care

Witness Date

Rev: 5/14/2019