



Authorization for Disclosure and Release of Medical and Mental Health Information

Name: _____ D.O.B: ____-____-____ Phone: _____-_____-_____
(Print)

Address: _____
(Street) (City) (State) (Zip Code)

I hereby authorize University of Maryland, Baltimore Student Counseling Services to:

- Release information to Receive information from Exchange information with

(Person/facility, address, phone, fax which has medical and/or mental health information)

Type of disclosure: Verbal/Written/Electronic Copies of record Letter

Purpose of disclosure: Ongoing treatment Academic Support Other _____
(specify)

By initialing below, you are authorizing the following information to be released:

(Initial) **All counseling/mental health information** (subject to MD’s Confidentiality of Medical Records Act, codified at Health-General 4-301et seq). Additionally, all information regarding Alcohol and/or Drug Abuse (42 C.F.R. and 2.35) or HIV/AIDS results (Health and Safety Codes 120980(g)) will be released **unless restricted in limitations below**.

(Initial) **All medication management services information medical information** (This may include but is not limited to drug/alcohol and mental health information documented by psychiatrist).

Limitations, if any, upon disclosure: _____

Type(s) of information: Initial Assessment Treatment Summary Attendance
 Psychiatric evaluation/medication history Other _____
(Specify)

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is _____ or 1 year from today’s date, whichever is sooner.
- I understand that I may revoke this authorization at any time and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that if I have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality law.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that a photocopy or fax of this form is the same as the original.

Signature of client

Date