Anne Arundel County Provider Network

A group of agencies working together to provide and coordinate Services

AUTHORIZATION FOR RELEASE OF INFORMATION

RELEASE FOR COORDINATION OF CARE AUTHORIZATION

RE: NAME (Please Print)_____ **DATE OF BIRTH**_____

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. This request will go to the agency or program's Medical Record or Health Information Department for processing. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

Yes	No	Provider/ Agency Name	Yes	No	Provider/ Agency Name
☐	☐	**Residential Rehabilitation Program:** Arundel Lodge, Omni, PTS and/or Vesta	☐	☐	**Hospitals/Inpatient** AAMC, BWMC, Laurel Regional, Sheppard Pratt, Other _____
☐	☐	**Fire Department:** Anne Arundel County, Annapolis City	☐	☐	**Police:** Anne Arundel County, Annapolis City
☐	☐	**Shelter:** Lighthouse Shelter, Sarah's House, Arundel House of Hope	☐	☐	**Detention Facilities:** Jennifer Road and Ordnance Road
☐	☐	**Psychiatric Rehabilitation Program:** Arundel Lodge, ASG, Care Connection, Foundations, Omni, PDG, PTS, Vesta	☐	☐	**Crisis Response System Services:** including mobile visits, phone contacts, interventions
☐	☐	**Case Management:** Community Residence, PDG	☐	☐	**Department of Social Services**
☐	☐	**Mental Health Provider:**_____	☐	☐	**Family Member:** _____
☐	☐	**Anne Arundel County Core Service Agency**	☐	☐	**Crisis Beds:** Psy Ki, Mosaic, SMCN, Safe Journey
☐	☐	**Anne Arundel County Partnership for Children, Youth and Families**	☐	☐	**Department of Juvenile Services**
☐	☐	**School:** _____	☐	☐	**Anne Arundel County Health Department**
☐	☐	**Maryland Commitment to Veterans**	☐	☐	**Other:** Please describe:
☐	☐	**Other:** Please describe:	☐	☐	**Other:** Please describe:

INFORMATION REGARDING THE ABOVE NAMED INDIVIDUAL FOR THE PURPOSE OF:

Coordination of Care and Entitlement Eligibility

INFORMATION RESTRICTED TO: Attendance, services received, compliance with recommendations, diagnosis, medications and side effects (if clinically necessary) with individual treatment plans, testing results, applications, previous providers, treatment plans, discharge summaries, and after care plans.

This permission expires automatically at the end of one year unless otherwise stated, but may be revoked by the patient's written request at any prior time except to the extent that action has been taken on it. Parent or legal guardian must sign in the case of a minor child (under age 16 for outpatient mental health services and under 18 for other medical and health services) unless an otherwise minor child is emancipated or permission is not necessary due to protection under the Minor Right Law.

BEFORE SIGNING - PLEASE READ CAREFULLY AND ASK QUESTIONS IF YOU HAVE ANY:

_____ _____

Patient/Parent/Legal Guardian Signature Date Agency Completing This Form Date

_____ _____

Witness Signature Date Release Valid Through