1800 North Charles Street, Suite 804
Baltimore, Maryland. 21201

HIPPA Authorization to Use and Disclose Protected Health Information

NOTICE – PLEASE READ: I understand that each authorization signed below will remain in effect for **180** days after I sign and date the form. Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of the written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization.

I understand that if I have authorized NP OnCall to disclose my information to a person who is not required by Federal or State law to keep the information confidential, these persons receiving my records may not disclose my protected health information to others without my consent or authorization. NPONCALL TMS will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

Notice To Recipient of Information: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules **prohibit the recipient of the protected health information from making further disclosure of this information** unless further disclosure is expressly permitted by the person's written consent to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Client Name: Date of Birth**:** / /

I hereby authorize the NP OnCall to:

☐ disclose information ☐ request information ☐ exchange information

With Name of Person or Entity: _____

Address: _____

Telephone/Fax: _____

INFORMATION TO BE USED/DISCLOSED
Initial the following items needed:

☐	Diagnostic Assessment/ Intake	☐	Psychological Evaluation Reports	☐	Treatment Plan/ISP
☐	Progress Notes	☐	Psychiatric Evaluation	☐	Other Social History
☐	Physician's Orders	☐	Court Reports/Records	☐	Medication Records
☐	School Records/ Consultation	☐	Laboratory Reports	☐	Employment Records/Reports
☐	Medical Status	☐	Drug and Alcohol Addiction Records	☐	Other

Other (CLEARLY SPECIFY)_____

Purpose for Disclosure: ☐ Assist in Treatment Planning ☐ Continuity of Care

☐ Other (Specify)

I understand that I may withdraw this consent at any time in the future as explained above and that this consent will expire in **180** days from the dates signed below, unless otherwise specified.

This consent will expire at Date

Signature: Relationship: Date:

Witness: Date:

NOTICE OF REVOCATION

I hereby, revoke authorization for further use and disclosure of my protected healthcare information effective immediately.

Client/Guardian Signature: Date Revoked: