Public Health
Prevent. Promote. Protect.
Somerset County
Health Department

Somerset County Health Department
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Health Officer Danielle Weber, MS, RN

Authorization for the Release of Confidential Information

Client Name: _____ DOB: _____ Patient ID#: _____
Street Address: _____
City, State, Zip: _____ Phone Number: _____

I hereby authorize the Somerset County Health Department to: Obtain ☐ Release ☐
information to / from: _____
The following information from my records (specify extent or nature of the information to be obtained or released): _____

_____

_____

The purpose of this authorized disclosure: _____

_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 and 164. These regulations prohibit you from making further disclosure of it without the specific written consent to whom it pertains or as otherwise specified by regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules may restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Conditions for Exchange of Authorized Information

Expiration: This authorization will expire one year from the date signed unless specified below by date or event less than one year: Date: ___/___/___ Event or Condition: _____

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice, but not retroactive to release of information already made in good faith.

USE SPACE BELOW ONLY IF CLIENT WITHDRAWS CONSENT.

Date Authorization Revoked by Client: ___/___/___ Signature of Client: _____

REDISCLOSURE: Any individual or agency receiving Somerset County Health Department client information is prohibited from making further disclosure of the medical record. This is prohibited as provided by the Annotated Code of Maryland 4-303(b)(5)(ii).

PHOTOSTAT/FACSIMILE: A photostat or facsimile of this authorization is considered as effective and valid as the original.

Signature of Client: _____ Date: _____
Signature of Parent or Guardian: _____ Date: _____
Witness to Signature: _____ Date: _____