GRASSROOTS CRISIS INTERVENTION CENTER
AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL RECORDS

I am a patient of Grassroots Crisis Intervention Center ("Grassroots"). By signing below, I authorize Grassroots to use or disclose my protected health information ("Information") as described below. I understand that signing this Authorization is **voluntary**.

Patient Name: _____
Patient Date of Birth: _____ **Patient Social Security Number**: _____
Patient Address: _____
Telephone Number of Patient: _____

My Information may be provided to the following individual or entity (insert name and address):

_____

Information to be disclosed:

☐ MCT Record for date_____ **or** (check all that apply)

☐ Diagnostic Reports ☐ Medication List ☐ Crisis Intervention for date: _____

☐ Referral Information ☐ Call report for date: _____ ☐ Other: _____

Are there date restrictions on the Information to be disclosed?

☐ No ☐ Yes (*specify the timeframe of the records*): _____

This Information is disclosed for the following purposes: _____

_____

_____

The patient or the patient's Personal Representative agrees with the following statements:

I understand that the Information disclosed may include information pertaining to abuse or neglect of a minor or adult, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental illness, the treatment of drug and alcohol abuse, or hepatitis C.

If you do not wish for this specific information to be disclosed, please describe the category(ies) of information to be excluded:

_____

1. I understand my treatment, payment, enrollment or eligibility for benefits will not be affected if this Authorization is not signed.
2. I understand that this Authorization will expire in one year, unless sooner revoked.
3. I understand that I may revoke this Authorization at any time by notifying Grassroots in writing, but if I do, it will not have any effect on any actions taken before Grassroots received the revocation.
4. I understand that there is potential that the recipient of the Information may redisclose the Information and the Information may no longer be protected by federal or state privacy laws.

_____ _____

Signature of patient or patient's Personal Representative Date

Printed name of patient's Personal Representative: _____

Description of authority to act for the patient: _____

No Grassroots employee may disclose medical records without a valid authorization from a patient (or his/her Personal Representative). Grassroots will not condition the provision of health care services based on a patient signing this authorization. A Personal Representative is not required to sign this form for an individual 12 years old or older "who is determined by a health care provider to be mature and capable of giving informed consent has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder." Md. Code Ann., Health-Gen. § 20-104.