



Release of Information

PO Box 9464, Silver Spring, MD 20916 • Phone (301) 774-3804

You may complete a separate release for each sending/receiving location, or you may leave the Name of Sending/Receiving Location blank, authorizing reuse of release as necessary.

Client Information

Full Name

DOB

Phone

Address, City, State, Zip

Release Authorization

Individual Granting Permission for Release (if different from client)

Title or Relationship to Client

Phone (if different from above)

Email

I hereby authorize the Director, Teacher and/or Counselor at House of Hope Maryland Day School to:

Send

Receive

To

From

Name of Outside Sending or Receiving Location

Phone

Fax

Address of Outside Sending or Receiving Location (include City, State, Zip)

Scope of Release

Information received by House of Hope Maryland Day School will be used for the following purposes: determining eligibility for placement, planning appropriate program, continuing appropriate program, case review.

Permission Granted For (check all that apply)

Permission for release of all areas below including tests, forms, reports, and other pertinent information

Academic testing results

Psychological testing results/reports

Individualized Education Plan

Service plans

Medical reports

Other, specify: _____

Notes or Limitations _____

Disclaimer for Authorization and Signature I authorize the release of my confidential protected information, as described in my directions above. I understand this authorization is voluntary, and refusal to sign will not jeopardize my right to obtain treatment. I understand that information disclosed is protected by state and federal law, and use/disclosure is to conform to my directions. I may revoke this authorization at any time in writing, except to the extent action has already been taken. The information used and/or disclosed pursuant to this authorization may be re-disclosed by recipient unless recipient is covered by state laws that limit use and/or disclosure of my confidential protected information and may no longer be protected by federal privacy regulations. I understand there are legal and ethical requirements that mandated reporters take responsible action in those situations as prescribed by law where there is danger of imminent harm to self or others, and in the case of apparent child abuse. I have been informed what information will be given, its purpose, and who will receive it. I understand I have a right to receive a copy of this authorization. If I am the legal guardian or representative appointed by the court for the client, I must attach a copy of the authorization to receive this protected information.

Signature

Title or Relationship

Date

Release expires one year after end of client's treatment unless otherwise revoked. Information has been disclosed from confidential records. Further disclosure without the specific written consent of client exceeds the limits of this release. Revised 12/2016