# AUTHORIZATION FOR RELEASE OR EXCHANGE OF INFORMATION

I, _____, hereby authorize and direct Upcounty Neuropsychology, LLC, and _____, to exchange the following information (check all that apply):

- ❑ Medical History
- ❑ Evaluations
- ❑ Developmental History
- ❑ Social History
- ❑ Progress Notes
- ❑ Test Results
- ❑ Diagnosis
- ❑ Treatment Summary/Plan
- ❑ Hospital/Medical Records
- ❑ Psychological Records
- ❑ Educational Records
- ❑ Psychotherapy Notes
- ❑ Other: _____ _____

Disclosure of this information is for the following purposes:

- ❑ Planning treatment/program
- ❑ Continuing ongoing treatment/program
- ❑ Professional Consultation
- ❑ Evaluation
- ❑ Transfer of Care
- ❑ Legal/Litigation Use
- ❑ Determining Benefits Eligibility
- ❑ Case / Utilization Review
- ❑ Coordination of Care
- ❑ Other: _____

The designated information ❑ **may** ❑ **may not** be transmitted by fax, email, or other electronic file transfer mechanisms.

I understand that these records contain information regarding my mental health and may be protected by federal and state law, including 45 C.F.R. §§ 160 and 164, and Maryland Code, Health–Gen. § 4-301 *et seq*. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I further understand that the recipient of this information may not be required to comply with these privacy rules and thus the information disclosed may not be protected from re-disclosure.

I certify that I give specific permission for the release of this information, that I give this consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

This authorization expires on _____ or in one (1) year, whichever date is sooner. I understand that I may revoke this authorization in writing at any time. I understand that I have a right to receive a copy of this authorization. I further understand that I have a right to refuse to sign this authorization.

DATED: this _____ day of _____, 20____

*SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:*

_____

*PRINTED NAME & RELATIONSHIP TO PATIENT IF PERSONAL REPRESENTATIVE:*

_____