WORCESTER COUNTY
LOCAL BEHAVIORAL
HEALTH AUTHORITY
Working together for healthier communities!

CONSENT TO *release/obtain* CONFIDENTIAL INFORMATION

In order to ensure continuity of care, I, _____

authorize Worcester County Local Behavioral Health Authority to exchange information with _____

_____

_____

for the purpose of the Homeless ID Project _____.

I understand that the information may/will include treatment for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or tests for HIV or AIDS.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be obtained without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) And that in any event this consent expires:

__**X**__ After one year from the date of execution.
_____ When the patient ceases to receive services from either agency.
_____ Other (Please specify)_____

Executed this _____ day of _____, 20____

DOB: _____ _____
Signature of Consumer, Parent, or Guardian

SSN: _____ _____
Signature of Witness

PLEASE DIRECT ALL CORRESPONDENCE TO:

Worcester County Health Department
Local Behavioral Health Authority
PO BOX 249
SNOW HILL, MD 21863

ATTENTION: _Worcester County Local Behavioral Authority____