111 PARK AVENUE ⅄ BALTIMORE, MARYLAND 21201 ⅄ 4108375533 ⅄ Fax: 4108378020

HEALTH CARE FOR THE HOMELESS

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, _____, _____,
Name SSN# Date of Birth

authorize Health Care for the Homeless - 111 Park Avenue - Baltimore, MD 21201- (410) 837-5533

to furnish information to the following persons/institutions:

_____
(Name)

_____
(Mailing Address)

_____
(City/State/Zip Code)

This information is to be limited to the following:

- ❒ **History and Physical**
- ❒ **Medical Progress Note**
- ❒ **Nursing Notes**
- ❒ **Medication Sheet**
- ❒ **Labs / X-Rays / Consultations**
- ❒ **Mental Health Records**
- ❒ **Addictions Records**
- ❒ **Social Service Records**
- ❒ **Other:** _____

0 The information designated above is intended to include information received from a third party provided the third party has not prohibited m-disclosure.

This information is to be released for the purpose of continuity of medical care.

I understand that my records are protected under federal, state confidentiality regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. 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 (i.e., information released prior to revocation), and that unless an earlier expiration is provided for below, this content automatically expires in one (1) year.

I understand that my medical records may contain information about such things as alcohol, drug use and/or HIV status.

This authorization shalt become effective immediately and shall be valid until: _____

Executed this _____ **day of** _____ **20**____.

_____ _____
(Client Signature) **(Witness Signature)**