Public Health
Prevent. Promote. Protect.
Wicomico County Health Department

Wicomico County Health Department

108 East Main Street • Salisbury, Maryland 21801

Matthew McConaughey, MPH, Health Officer

Accredited Health Department • PHAB Advancing Public Health Performance • Public Health Accreditation Board

INDIVIDUAL'S AUTHORIZATION

THIS FORM IS USED TO CONFIRM THE DIRECTION OF AN INDIVIDUAL TO AUTHORIZE THE WICOMICO COUNTY HEALTH DEPARTMENT TO ☐ REQUEST, TO USE, AND/OR TO ☐ DISCLOSE THE INDIVIDUAL'S HEALTH INFORMATION.

PLEASE TYPE OR PRINT NEATLY; WE ARE NOT ABLE TO PROCESS INCOMPLETE OR ILLEGIBLE FORMS.

☐ **CHECK IF THIS AUTHORIZATION IS FOR PSYCHOTHERAPY NOTES.**

IF THIS AUTHORIZATION IS FOR PSYCHOTHERAPY NOTES, WICHD WILL NOT USE IT AS AN AUTHORIZATION FOR ANY OTHER TYPE OF HEALTH INFORMATION. IF THE INDIVIDUAL SEEKS TO AUTHORIZE THE USE AND DISCLOSURE OF OTHER HEALTH INFORMATION AS WELL, AN ADDITIONAL FORM MUST BE SUBMITTED.

SECTION A: INDIVIDUAL'S HEALTH INFORMATION AUTHORIZED FOR USE AND DISCLOSURE.

Last Name_____ **Middle:** _____ **First:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone (Home): _____ **DOB:** _____ **PT ID:** _____

SECTION B: THE USE AND/OR DISCLOSURE BEING AUTHORIZED: PROVIDE A DETAILED DESCRIPTION OF THE HEALTH INFORMATION; YOU ARE AUTHORIZING US TO USE AND/OR DISCLOSE.

I.) Provide Financial Assistance/Continuity of Care_____

WHO IS AUTHORIZED TO x DISCLOSE x RECEIVE AND USE YOUR HEALTH INFORMATION?

Wicomico Behavioral Health Authority

108 E. Main St.

Salisbury, MD 21801 410-543-6981

WHO IS AUTHORIZED TO x DISCLOSE x RECEIVE AND USE YOUR HEALTH INFORMATION?

INDIVIDUAL'S AUTHORIZATION (CONTINUED)

OTHER:

_____

_____

_____

If the information which the program has includes records or information from another entity,
I ☐ do or ☐ do not wish to have that information released under this authorization.

SECTION C: EXPIRATION AND REVOCATION.

(If this section is not completed, WiCHD cannot accept this form.)

This authorization will expire (complete one):

☐ ON _____

☐ ON OCCURRENCE OF THE FOLLOWING EVENT (WHICH MUST RELATE TO THE INDIVIDUAL OR TO THE PURPOSE OF THE USE AND/OR DISCLOSURE BEING AUTHORIZED): _____

Right to Revoke: *I understand that I may revoke this authorization at any time by giving written notice of my revocation to WiCHD. In order to obtain a revocation form to revoke this authorization, I understand that I may contact the office of the WiCHD Health Officer/Deputy Health Officer. I understand that revocation of this authorization will not affect any action that WiCHD or others named or unnamed took in reliance on this authorization before WiCHD received my written notice of revocation.*

SECTION D: SIGNATURE

I authorize the use and/or disclosure of my health information as described in section B above. I understand this authorization is voluntary.

I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. If the request for information concerns treatment of alcohol or other substance abuse, the confidentiality of the information is protected by federal law 42 CFR Part 2. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

Signature: _____ **Date:** _____

If a personal representative is making this request, a copy of any document granting legal authority is required. Complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____