MARYLAND OFFICE OF THE PUBLIC DEFENDER

NATASHA DARTIQUE
PUBLIC DEFENDER

KEITH LOTRIDGE
DEPUTY PUBLIC DEFENDER

INDIVIDUAL'S AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO THE OFFICE OF THE PUBLIC DEFENDER

PURPOSE: To AUTHORIZE THE OFFICE OF THE PUBLIC DEFENDER to REQUEST AND RECEIVE, to USE and/or DISCLOSE the individual's health information at the request of the individual.

CLIENT

Last Name: _____ First Name: _____ MI: _____

Address: _____ DOB: _____

HEALTH INFORMATION BEING REQUESTED FOR DISCLOSURE and/or RELEASE:

Date(s) of Service: _____

[ ] Inpatient	[ ] Admission Notes	[ ] Consultation	[ ] Substance Abuse Records
[ ] Outpatient	[ ] History & Physical	[ ] Emergency Room Records	[ ] Psychiatric/Psychological Reports
[ ] Day Program	[ ] Medical Tests	[ ] Discharge Summary	[ ] Psychosocial History
[ ] Residential	[ ] Labs	[ ] Mental Health	[ ] Treatment Team Notes
[ ] Entire Record	[ ] Other Medical Records: _____		

This disclosure is for legal purposes.

NAME OF FACILITY, HOSPITAL, PROGRAM OR INDIVIDUAL AUTHORIZED TO DISCLOSE, and/or RELEASE INFORMATION:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

EXPIRATION AND REVOCATION OF AUTHORIZATION:

Thirty (30) days after the disposition of my case (*Health General § 4-303(b)(4)(i)),* this authorization is no longer valid. I may also choose to end this authorization sooner on the date here indicated: ____/_____/_____.

I understand that I may revoke this authorization at any time by giving written notice of revocation to the health care provider listed above and to the Office of the Public Defender. I understand that revocation of this authorization will not affect an action that the Office of the Public Defender or others named or unnamed took in reliance on this authorization before the health care provider listed above or the Office of the Public Defender received my written notice of revocation.

CLIENT STATEMENT

- I have read and understand the contents of this authorization, and I give my consent to the Office of the Public Defender to disclose and/or release the health information obtained by it in connection with the representation of me.
- I understand that if the person(s) or organizations I authorize to receive and/or use my health further disclose the health information, and the health information privacy laws may no longer protect it.
- I understand this authorization is voluntary.
- If the information requested includes records or information from another agency, doctor, or hospital, I do wish to have that information released under the authorization.
- I am not required to sign this authorization to receive services from the health care provider.
- I understand that the information released may contain alcohol/drug abuse, psychiatric HIV testing, HIV results, or AIDS information.

Client Signature: _____ Date:_____

Guardian/Parent/Personal Representative: _____ Date: _____