Anne Arundel Medical Group
Mental Health Specialists

Authorization to Disclose Protected Health Information

Communication between your mental health provider(s), your primary care provider (PCP) and other designated specialist provider/s is important to make sure all care is complete, comprehensive and well-coordinated. This form allows AAMG Mental Health Specialists to share valuable information with your PCP and other providers. No protected information will be released without your signed authorization.

For the purposes of this disclosure, protected information is limited to Psychotherapy services.

Section 1. The Patient

Last Name:____________________________ First Name:____________________________ Middle Initial:___________

Date of Birth (MM/DD/YYYY):____________________________ Phone Number:________________________________

I hereby authorize the disclosure of protected health information about the individual named above. I am:

- ❑ The individual named above (complete Section 8 below to sign this form)
- ❑ A personal representative, because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Patient?

The following Mental Health provider may disclose the information:_____**AAMG Mental Health Specialists**_______________________

Phone Number (if known): ________**410 573-9000**____

Section 3. Who Will Be Receiving Information About the Patient?

The information may be disclosed to the following Primary Care provider, Specialty provider, or treatment facility:

Entity #1

Name (a person, and an organization if you are naming a practice):____

Phone Number (if known):_______________________ Street Address (if known):_______________________________

Suite:__________ City:__________________________ State:_________________ Zip Code:______________

Entity #2

Name (a person, and an organization if you are naming a practice):____

Phone Number (if known):_______________________ Street Address (if known):_______________________________

Suite:__________ City:__________________________ State:_________________ Zip Code:______________

Last Name:___________________________ First Name:___________________________ Middle Initial:___________

Section 4. What Information About the Patient Will Be Disclosed?

❑ Any applicable Mental Health and/or substance abuse information and/or records. Or:

❑ Other (please describe, you may limit by provider, date span, service type, etc) ____________________________________

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Section 5. The Purpose of the Disclosure

To release Mental Health evaluation and/or treatment information to the identified provider/s to ensure quality and coordination of care.

Section 6. The Expiration Date or Event

This authorization shall expire 1 year from the date of signature in section #8 or #9 below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by notifying us in writing. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure of protected information.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting our office.

Section 8. Signature of the Patient

Signature____ Date (required) ___________________________________

Section 9. Signature of Personal Representative (if applicable)

Name: ____

Signature____ Date (required) ___________________________________

Relationship to the individual (required): ____