AUTHORIZATION TO RELEASE CONFIDNETIAL INFORMATION
Christina Meighen, LLC
1997 Annapolis Exchange Parkway, Suite 300
Annapolis, MD 21401

I, _____ hereby authorize Christina Meighen, LLC.
(printed name of client or parent/legal guardian)

To release/receive the following information to/from: _____
(Name of agency, program, or individual)

Located at _____
(Complete address and phone number)

Christina Meighen, LLC to **Release**	Christina Meighen, LLC to **Receive**
__ Intake Assessment	__ Intake Assessment
__Treatment Plan	__Treatment Plan
__ Assessments/ASI	__ Assessments/ASI
__ Mental Health Assessment	__ Mental Health Assessment
__ Client Information (profile)	__ Client Information (profile)
__ Encounter Detail/Progress Notes	__ Encounter Detail/Progress Notes
__ e-court case management	__ e-court case management
__ Drug Test Results	__ Drug Test Results
__ Miscellaneous Note Detail	__ Miscellaneous Note Detail
__ Discharge/Closing Summary	__ Discharge/Closing Summary
__ Medical History	__ Medical History
__ Date range of record to be released _____	__ Date range of record to be released _____
__ Other (please specify) _____	__ Other (please specify) _____

The record of _____
(name of Client) (Social Security No.) (Date of Birth)

I understand that this information will be used for the purpose of _____.

The consent to disclose information from my medical records may be revoked by me, in writing at any time except to the extent that action has been taken in reliance thereon. Unless I revoke it earlier, in writing, to Christina Meighen, this authorization will expire in:

☐ 30 Days ☐ 60 days ☐ 90 days ☐ 180 days or, ☐ one year

from the date below. If no decision for the consent expiration is entered, it will be considered valid for one year from the date entered below.

I authorize the use of a copy (including electronic copy) of this from for the disclosure of the information described above.

I understand that the information contained in my medical record contains confidential information that may include chemical/substance abuse and HIV information. This information may be protected by Federal and State law. I understand that pursuant to these statutes and regulations, Christina Meighen, LLC may refuse to disclose portions of my record. I further understand that Christina Meighen, LLC. shall only release this information to the agency or person named above, and understand that this information may be subject to re-disclosure by the recipient and may no longer be protected by HIPPA. I understand that refusing to sign this form will not impact my treatment at Christina Meighen, LLC.

I acknowledge I have received a copy of this form. Signed this ___ day of _____, 20 ____

_____
printed name and signature of Client

_____
Address of Client

_____
Signature of witness

PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S. C. 290dd-3 and 42 U.S.C. 290 ee-3 for Federal laws and 42 CFR Part 2 for Federal Regulations) Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of these records without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this.