

WORCESTER COUNTY HEALTH DEPARTMENT
MENTAL HEALTH CLINIC
P.O. BOX 249
SNOW HILL, MARYLAND 21863
PHONE: 410-632-1 100 FAX: 410-632-0906

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

In order to ensure continuity of care, I, _____
authorize Worcester County Health Department to exchange with _____
_____ the following information:

- ___ Disclosure of Information _____

___ Request Information _____

I understand that the information may/will include treatment for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or tests for HIV or AIDS.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. 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 (e.g. probation, parole, etc.) And that in any event this consent expires:

- ___ After one year from the date of execution.
___ When the patient ceases to receive services from either agency.
___ Other _____

Executed this _____ day of _____ 119 _____

DOB: _____

Signature of Patient, Parent, or Guardian

SSN: _____

Signature of Witness

PLEASE DIRECT ALL CORRESPONDENCE TO:

**Worcester County Health Department
Mental Health Clinic
P.O. Box 249
Snow Hill, Maryland 21863**

ATTENTION: _____
CHRELEASECONFIDINFO

SITE: _____