LCT Release Authorization

Washington County Local Care Team (LCT)
Authorization for Release of Interagency Protected Health Information (HIPAA)

Parent/Guardian Information:

Name:	Address:	Phone Number:	Email Address:

Client (Child) Information:

Name:	Date of Birth:

Purpose:

I, _____, authorize the release of my protected health information as described below. This authorization is in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 CFR § 164.508.

Information to be Disclosed:

I authorize the disclosure of the following protected health information:

- ☑ Department of Juvenile Services information
- ☑ Developmental history, including psychological evaluations and treatment
- ☑ Diagnostic test results
- ☑ Medical history
- ☑ Medication information
- ☑ Psychiatric
- ☑ Social history
- ☑ Treatment records
- ☑ Any other information pertinent to my healthcare
- ☑ Other:_____

Recipient of Information:

The disclosed information will be provided to:

- ☑ Developmental Disabilities Administration
- ☑ Department of Juvenile Services
- ☑ Division of Rehabilitative Services
- ☑ Governor's Office for Children
- ☑ Maryland Coalition of Families
- ☑ Maryland Department of Health
- ☑ Potomac Community Services
- ☑ Washington County Dept. of Social Services
- ☑ Washington County Health Department
- ☑ Washington County Local Management Board
- ☑ Washington County Mental Health Authority
- ☑ Washington County Public Schools
- ☑ Other:_____

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Purpose of Disclosure:

The disclosed information is being released to allow the Washington County LCT to use it for assessment, evaluation, and planning to deliver services for the client.

Rights of Clients and Guardians under HIPAA:

I understand that under HIPAA, I have the following rights:

- The right to request restrictions on using and disclosing my protected health information.
- The right to receive confidential communication of my health information.
- The right to inspect and obtain a copy of my health records.
- The right to request amendments to my health records if I believe them inaccurate or incomplete.
- The right to receive an accounting of disclosures of my health information.
- The right to file a complaint if I believe my privacy rights have been violated.

Expiration and Revocation:

This authorization expires one year from the date it is signed, unless I revoke it earlier in writing. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it.

Amendment Requests and Complaints:

For any requests for amendments to records or to file complaints regarding the handling of my health information, I understand that I can contact:

LCT Coordinator
Nedra Wingate-Dix
contact@wclct.org
240-391-8446 (text)

Acknowledgement:

I acknowledge that I have read and understand the purpose of this authorization, which is to release protected health information. I understand the information that will be disclosed and the rights afforded to me under HIPAA.

Parent/Guardian Signature:

[Signature]

[Date]

[Printed Name]

Witness Signature (if applicable):

[Signature]

[Date]

[Printed Name]