RELEASE FOR COORDINATION OF CARE AUTHORIZATION

**RE: NAME (Please Print): \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_**

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. This request will go to the agency or program’s Medical Record or Health Information Department for processing. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Yes** | **No** | **Provider/Agency Name** | **Yes** | **No** | **Provider/Agency Name** |
| ❒ | ❒ | **Crisis Response System Services:** including mobile visits, phone contacts, interventions | ❒ | ❒ | **Shelters:** Lighthouse Shelter, Sarah’s House, Arundel House of Hope |
| ❒ | ❒ | **Anne Arundel County Core Service Agency** | ❒ | ❒ | **Mental Health Provider:** M&M Behavioral Health, Omni, Arundel Lodge, Pascal |
| ❒ | ❒ | **Police Department:** Anne Arundel County, Annapolis City, Sheriff’s Office, MD State Police, MDTA | ❒ | ❒ | **Residential Rehabilitation Program:** Arundel Lodge, Omni, PTS, Vesta |
| ❒ | ❒ | **Fire Department:** Anne Arundel County, Annapolis City | ❒ | ❒ | **Case Management/Psychiatric Rehabilitation Program:** Community Residence, Vesta, Omni, Arundel Lodge, PTS, PDG, TIME, Center for Children |
| ❒ | ❒ | **Hospitals:** AAMC, BWMC, Harbor Hospital | ❒ | ❒ | **Developmental Disabilities Association** |
| ❒ | ❒ | **Emergency Contact:** | ❒ | ❒ | **Anne Arundel County Department of Aging** |
| ❒ | ❒ | **Anne Arundel County Department of Health** | ❒ | ❒ | **Anne Arundel County Department of Social Services** |
| ❒ | ❒ | **Anne Arundel County State’s Attorney** | ❒ | ❒ | **School:** |
| ❒ | ❒ | **Maryland Office of the Public Defender** | ❒ | ❒ | **Anne Arundel County Department of Juvenile Services** |
| ❒ | ❒ | **Crisis Beds:** Harbour House, Pascal | ❒ | ❒ | **Detention Facilities:** JRDC and ORCC |
| ❒ | ❒ | **SUD Provider**: Pathways, Hope House, Gaudenzia, Arundel Lodge, First Step Recovery, Delphi Behavioral, Avenues Recovery, Walden Sierra, Mountain Manor, Hudson Health, Whitsitt Center, Hopes Horizon, Warwick Manor, Joseph S. Massie Unit | ❒ | ❒ | **Anne Arundel County Parole, Probation & Pretrial** |
| ❒ | ❒ | **Secret Service, Federal Bureau of Investigation, National Security Agency** |
| ❒ | ❒ | **SUD Housing:** Serenity Sistas, Evolve, Stepping Stones, Oxford House, Uplift Recovery, Liberty House, Grace House, Opportunity Ministries, Samaritan House, Damascus House, Chrysalis House | ⌧ | ❒ | **Landlord of current residence** |

**INFORMATION REGARDING THE ABOVE NAMED INDIVIDUAL FOR THE PURPOSE OF:**

Coordination of Care and Entitlement Eligibility

**INFORMATION RESTRICTED TO:** Attendance, services received, adherence with recommendations, diagnosis, medications and side effects (if clinically necessary) with individual treatment plans, testing results, applications, previous providers, treatment plans, discharge summaries, and after care plans.

This permission expires automatically at the end of one year unless otherwise stated, but may be revoked by the patient’s written request at any prior time except to the extent that action has been taken on it. Parent or legal guardian must sign in the case of a minor child (under age 16 for outpatient mental health services and under 18 for other medical and health services) unless an otherwise minor child is emancipated or permission is not necessary due to protection under the Minor Right Law.

**BEFORE SIGNING - PLEASE READ CAREFULLY AND ASK QUESTIONS IF YOU HAVE ANY:**

ACDS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Parent/Legal Guardian Signature Date Agency Completing This Form Date

\_\_\_\_\_\_\_\_

Witness Signature Date Release Valid Through