7121 Old Alexandria Ferry Road
Clinton, MD 20735
Phone: (301) 856-5553
Fax: (301) 856-5512

5400 Norfield Road
Capitol Heights, MD 20743
Phone: (301) 736-6622
Fax: (301) 856-5512

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name _____ Birthdate _____

Address _____ City, State, Zip _____

I hereby authorize _____
(Hospital, Program, Physician's Office and/or Social Services)
to release to **Helping Hands Adult Day Services** the following medical records and/or or other information. The extent or nature of information to be released is indicated below:

Medical Records _____ Social Services Records _____
Discharge Summary _____ Medical Sheets _____

X-rays (specify) _____

Laboratory Report (specify) _____

Other _____

The purpose for release of the above information is indicated below:

Medical Day Program Enrollment _____ Continued Care _____
Legal _____ Insurance _____

Other (Please specify) _____

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, signed communication to **Helping Hands Adult Day Services.**

_____ _____
Signature of Patient Date signed

_____ _____
Signature of parent, guardian or legal representative Witness

If signed by other than patient, state relationship and reason for patient's inability to sign.

_____

_____

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability (HIPAA)