**State of Maryland**

**HIPAA Release Form**

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your certification and other related information to be shared as requested.

Section I

I, ------------------------------------------------------ give my permission for --------------------- to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Certifications and other related Information about me

I would like to give the above healthcare Agency permission to:

Disclose my complete Certifications and health record including, but not limited to, diagnoses, lab test result, treatment, and billing records for all conditions.

Except for the following information

Mental health records

Communicable diseases including, but not limited to, HIV and AIDS

Alcohol/drug abuse treatment records

Genetic information

Other (specify): ----------------------------------------------------------------------------------

Form of Disclosure:

Electronic copy or access via a web-based portal

Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write “at my request”. eg. For Job purposes

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Section IV – Who can Receive my Certifications and other related documents including my health information

I give authorization for certification and all related information including health information detailed in Section II of this document to be shared with the following agency’s or organization(s)

Name: -------------------------------------------- Agency: Arc health care services Inc

Address: 36 Greenbury Ct Gwynn oak md 21207

I understand that the person(s) organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my certifications and health related information is valid (please choose one of the following)

From: ------------------------------------------ To: ------------------------------------------

All past, present and future periods

The date of the signature in Section VI until the following event

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I understand that:

I am permitted to revoke this authorization to share my certifications and any other related health data at any time and can do so by submitted a request in writing.

In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my Certifications and any other related health documents.

I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in Section IV.

Failure to cancel this authorization will not prevent me from leaving the company after the 90 day’s notification.

Section VI

Signature;-------------------------- Date……………………………………….

Print your name………………………………………………………………………………………