Jessica Fitzwater
County Executive

FREDERICK COUNTY GOVERNMENT

Division of Aging & Independence *Carolyn B. True, Director*

Division of Aging & Independence (DAI)
Authorization to Release Information

FOR YOUR PROTECTION, ALL RECORDS REQUEST FORMS YOU SUBMIT (INCLUDING BILLING/INVOICE REQUESTS) MUST BE ACCOMPANIED BY A COPY OF YOUR VALID DRIVER'S LICENSE OR OTHER VALID GOVERNMENT ID. If any legally authorized person has requested Protected Health Information (PHI), we require a copy of that person's valid driver's license or other valid government ID along with documentation that they are legally authorized to act on our patient's behalf (such as a Power of Attorney). In limited circumstances, we may deny you access to PHI, and you may appeal certain types of denials by contacting the HIPAA Compliance Officer by sending an email to: HIPAACompliance@FrederickCountyMD.gov or by phone at 301-600-1308. We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state or federal law.

Please be aware that after any authorized disclosure by DAI, we are no longer responsible for the security of that information released to others. In other words, your health information may not be classified as Protected Health Information by the parties to whom you have authorized disclosure, and you may not be entitled to the protections for your personal health information that are afforded under federal and/or state privacy laws. To the extent that your request has not already been processed, you may cancel your request for disclosure by writing to the Division of Aging & Independence, attn: Custodian of Records at the address below or by emailing DAI@FrederickCountyMD.gov

For all records requests, please complete the form located on the next page of this document and return that page to the Division of Aging & Independence, attn: Custodian of Records **(along with a copy of your valid identification and any documents authorizing you to request records for someone else)** using one of the following methods:

Encrypted email: DAI@FrederickCountyMD.gov
or
USPS/US Mail to: Division of Aging & Independence
attn: Custodian of Records
(or in person) 1440 Taney Ave
Frederick, MD 21702
or Fax to: 301-600-3554

We will process your request within 21 calendar days or notify you of why we are not able to process your request.

Significant change to ALL Record Requests for parties requesting records for the following purposes:

- **Health oversight activities**
- **Judicial or administrative proceedings**
- **Law enforcement**
- **Regarding decedents, disclosures to coroners and medical examiners**

The Attestation For Reproductive Health Records MUST be completed by the party that is receiving Protected Health Information & returned to Frederick County, Maryland Division of Aging & Independence before records (including billing records) will be disclosed!

The Frederick County, Maryland Division of Aging & Independence considers all protected health information (PHI) for all patients to be potentially inclusive of information related to reproductive health care provided by a third party in the state of Maryland. We presume this care to be lawful under the circumstances in which it was provided. Pursuant to the 2024 Privacy Rule amendment to the Health Insurance Portability and Accountability Act of 1996 (commonly referred to as HIPAA), the Division of Aging & Independence is required to obtain an Attestation that medical or billing records which may contain highly sensitive personally identifiable health information will not be used for specific prohibited purposes and/or will not be shared with another person after disclosure by the Division of Aging & Independence. This attestation requirement includes requests made for health oversight activities, judicial and administrative proceedings, law enforcement purposes, and disclosures to coroners and medical examiners.

The party who is RECEIVING the PHI must notify DAI of the need for an Attestation, then sign and return the form to the Division of Aging & Independence at:

Frederick County, Maryland
Division of Aging & Independence
attn: Custodian of Records
1440 Taney Ave
Frederick, MD 21702

or by emailing: DAI@FrederickCountyMD.gov

If you are unable to agree to the attestation verbiage, do not sign the form. If you do not sign and return the Attestation document, then per HIPAA mandates the PHI records (including billing records) will not be released to you.

Any person who knowingly and in violation of HIPAA falsifies an attestation (e.g., makes a material misrepresentation about the intended uses of the PHI requested) to obtain or cause to be disclosed an individual's IIHI/PHI may be subject to the criminal penalties provided by the statute. Furthermore, there are potential criminal penalties for those who knowingly and in violation of HIPAA obtain or disclose to another person individually identifiable health information (IIHI) of highly sensitive nature, such as mental health records and/or reproductive health records.

Frederick County, Maryland
Division of Aging & Independence
Authorization to Release Information

Patient Name: _____ Date of Birth: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Email: _____

I authorize Frederick County, Maryland Division of Aging & Independence to release the following information from my medical record (If you do not wish to disclose specific sensitive information in your record, indicate any specific restrictions on disclosure here –if there are no specific restrictions listed, the record will be sent without redactions):

____ **Treatment/medical record** for the following Date(s) Of Service/Incident _____ (to _____)
Restrictions (e.g., protected status such as HIV status, genetic condition, reproductive status, etc.): _____

____ **Billing and Payment records** for the following Date(s) Of Service/Incident: _____ (to _____)
Restrictions (e.g., protected status such as HIV status, genetic condition, reproductive status, etc.): _____

____ **Other** (describe) _____

I authorize the following person or organization to receive the information:

Name (*required*): _____
Mailing Address: _____
I prefer the records to be emailed/faxed to this email address/fax number: _____
I prefer my records be provided in the following alternate format: _____
The purpose of this disclosure is: __ At my request __ Other (describe): _____

This authorization will expire 1 year after the date of my signature, or sooner by choice, in which case this authorization will expire on _____, except to the extent action has already been taken in reliance upon this authorization.

I authorize the release of any information contained in my treatment and/or billing records that might contain sensitive information including information concerning diagnosis and/or treatment of alcohol or substance abuse, drug related conditions, mental health conditions, developmental disabilities, sexually transmitted diseases, communicable diseases, genetic testing, and/or HIV/AIDS related condition(s), except as noted above.

I understand the treatment information released pursuant to this authorization could be subject to redisclosure by the recipient and may no longer be protected by federal law. If the information released pursuant to this authorization includes alcohol or drug treatment records, the person(s) receiving this information are hereby notified that federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that I may revoke this authorization at any time by contacting the Division of Aging & Independence Custodian of Records in writing. I further understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that Frederick County, Maryland and its workforce are released from legal responsibility or liability for disclosing protected health information authorized by my signature below.

_____ _____
Printed name of Requestor Date

_____ _____
Signature of Requestor Relationship, if the Requestor is not the Patient

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Date Received: _____ ID Verified: _____ Date Processed: _____

Notes: _____ Revised: 01/15/2025