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

<u>FOR YOUR PROTECTION, ALL HEALTH RECORDS REQUEST FORMS YOU SUBMIT (INCLUDING BILLING/INVOICE REQUESTS) ARE TREATED AS CONFIDENTIAL UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (AND SUBSEQUENT UPDATES), also known as HIPAA.</u>
The Frederick County, Maryland Division of Aging and Independence is a covered entity under HIPAA and abides by the privacy and security restrictions within HIPAA. If you have questions or concerns about the privacy of your health information, please contact the Division of Aging & Independence at 301-600-1234 or contact the Frederick County, Maryland HIPAA Compliance Officer by sending an email to: HIPAACompliance@FrederickCountyMD.gov or by phone at 301-600-1308. You may find additional information regarding your rights and our responsibilities related to your privacy in our Notice of Privacy Practices.

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

Patient Name: ____ Date of Birth: ______________ Phone: _________________
Street Address: ____
City: ____ State: ________ Zip: ____________
Email: ____

I authorize ____ to release the following information from my medical record; note here any restrictions on the type of information to be released.

____ **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 request that you accept this authorization to release my records to the following organization:

Name: Frederick County, Maryland Division of Aging & Independence
Mailing Address: 1440 Taney Ave, Frederick, MD 21702
I prefer the records to be faxed to this fax number: 301-600-3554
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.

____ ________________________
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