



GENERAL CONSENT FORM AUTHORIZATION OF DISCLOSURE

Individual's Name (Please Print) _____

Social Security # _____

Date of Birth _____

I authorize HUMANIM to *release and obtain* the following confidential written and verbal information, including, but not limited to, facsimile and electronic communication, for the purpose of evaluation for placement, and/or participation, and/or continuity of care in HUMANIM rehabilitation services, *from and to*:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

☐ Medical/Dental

☐ Treatment Plan

☐ Medication Lists (current preferred)

☐ Intake Assessments

☐ Drug/Alcohol

☐ Discharge Summaries

☐ Behavior Plan/Data

☐ Vocational

☐ Psychiatric/Psychological/Neuropsychological Evaluation

☐ Educational

☐ Progress Notes

☐ Other _____

☐ Other information pertinent/necessary for effective delivery
of psychiatric/psychological rehabilitation services

☐ Dates of Service _____

I understand that this consent to *release and obtain* information may be revoked by me in writing at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, **this consent form will expire one year from the date of signature.** A photo static copy of this consent/authorization shall be considered as effective and valid as the original.

Signature of the Individual/Patient

Date

Signature of Witness

Date

Signature of Parent, *Guardian or Legal representative (If applicable)

Date

Specify Relationship to Individual/Patient

*Please note that court documentation must be provided if you have guardianship or are the legal representative.

(Revised 7/21/08)

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