Jessica Fitzwater
County Executive

FREDERICK COUNTY GOVERNMENT

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

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

FOR YOUR PROTECTION, ALL RECORD 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 the participant'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 (Pamela Maliszewskyj) by emailing 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, Attention: Custodian of Records at the address below or by emailing dai@frederickcountyMD.gov.

For all record requests, please complete the form located on the next page of this document and return that page to the Division of Aging & Independence, Attention: 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: Melinda Lohman-Hinz, mhinz@frederickcountymd.gov

or

USPS/US Mail to: Frederick County Division of Aging & Independence
Attention: Custodian of Records
(or in person) 1440 Taney Avenue
Frederick, MD 21702

or Fax to: 301-600-3554

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

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

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: 08/13/2025