Redefining the Future NETWORK

Wellbeing Redefined. Life Reimagined.

Redefining the Future Network, Inc.
3500 Boston Street, Suite 434
Baltimore, Maryland 21224
Phone 443.429.1985 | Fax 410.994.4598
documents@rtfnetwork.com | www.rtfnetwork.com
Outpatient Mental Health | PRP | SUD | Supported Employment

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION

To Redefining the Future Network, Inc. (RTFNetwork) - Incoming Records Request

This form lets a client authorize another provider or agency to send their behavioral health records to RTFNetwork. It is designed to meet HIPAA (45 CFR 164.508), 42 CFR Part 2, and the Maryland Confidentiality of Medical Records Act (Md. Code, Health-General 4-301 et seq.). Complete every section; incomplete forms may be refused by the releasing party.

SECTION 1 - CLIENT INFORMATION

Client full legal name | **Other names used (maiden, alias)**

Date of birth (MM/DD/YYYY) | **Last 4 of SSN (optional)** | **Phone** | **RTFNetwork client ID (office use)**

Street address | **City** | **State** | **ZIP**

Email

SECTION 2 - RELEASING PARTY (PROVIDER OR AGENCY DISCLOSING RECORDS)

I authorize the following provider, program, or agency to release my records:

Name of provider / program / agency | **Contact person and title**

Street address | **City** | **State** | **ZIP**

Phone | **Fax** | **Email**

Dates of service to be released: From | **To**

SECTION 3 - RECIPIENT OF INFORMATION

The records above are to be released ONLY to:

Redefining the Future Network, Inc. (RTFNetwork)
ATTN: Records
3500 Boston Street, Suite 434
Baltimore, Maryland 21224

Phone: 443.429.1985
Secure fax: 410.994.4598
Secure email: documents@rtfnetwork.com
Website: www.rtfnetwork.com

SECTION 4 - INFORMATION TO BE RELEASED

Check each item you authorize. Anything left unchecked will NOT be released.

- Intake / biopsychosocial assessment
- Psychiatric evaluation
- Treatment / service plan and goals
- Medication list and medication management
- Diagnosis and diagnostic impressions
- Psychological or educational testing
- Progress notes and attendance*
- Crisis, safety, or risk assessments

- Hospitalization and discharge summaries
- Laboratory results / toxicology screens
- IEP / 504 Plan (for minors)
- Vocational / employment records
- Entire record (all of the above)
- Other (specify):

**Progress notes do not include psychotherapy notes.*

Specially protected information - separate initials required

Federal and Maryland law give these records extra protection. Initial each one you authorize.

Category	Initials
Substance use disorder (SUD) records. Records protected by 42 CFR Part 2, including SUD diagnosis, treatment, and toxicology results.	
SUD counseling notes. 42 CFR 2.31(b) - may not be combined with other consents; requires a separate form.	*Not authorized on this form*
Psychotherapy notes. 45 CFR 164.508(a)(2) - requires a separate authorization.	*Not authorized on this form*
HIV/AIDS information. HIV/AIDS testing or treatment information.	
Genetic information. Genetic testing information.	
Sexual / reproductive health. Records of sexual or reproductive health care.	

Format of release: Paper / fax Secure electronic Verbal discussion between providers

SECTION 5 - PURPOSE OF DISCLOSURE

The information will be used only for the purposes checked:

- Continuity of care / coordination of treatment
- Assessment, intake, and treatment planning
- Referral, admission, or transfer of care
- Medication management / psychiatric services
- PRP or supported employment services
- Eligibility determination / service authorization
- At the request of the client
- Other (specify):

For SUD records only: If I consent below, RTFNetwork may use and redisclose my Part 2 records for treatment, payment, and health care operations as permitted by HIPAA, consistent with 42 CFR 2.33(b).

I consent to TPO use of my SUD records **I do not consent**

SECTION 6 - EXPIRATION

This authorization expires on the earliest of the dates or events checked below. If none is checked, it expires ONE YEAR from the date signed. A copy or fax of this signed form is as valid as the original.

- On this date:
- Upon discharge from RTFNetwork services
- Upon this event:

SECTION 7 - CLIENT RIGHTS AND REQUIRED NOTICES

Please read and initial each statement.

Statement	Initials
Right to revoke. I may revoke this authorization at any time by giving written notice to the releasing party named in Section 2 (with a copy to RTFNetwork). Revocation does not apply to information already released in reliance on this authorization.	
No conditioning. The releasing party may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except as allowed by law.	

Voluntary. I am signing this authorization voluntarily. I may refuse to sign it.	
Redisclosure. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA. RTFNetwork will protect my records under federal and Maryland law and will not redisclose them without my authorization except as the law permits.	
SUD records. Records protected by 42 CFR Part 2 may not be used or disclosed in any civil, criminal, administrative, or legislative investigation or proceeding against me without my written consent or a court order that meets Part 2 requirements.	
Copy. I have the right to receive a copy of this signed authorization.	
Questions or complaints. I may contact the RTFNetwork Privacy Officer at 443.429.1985, or file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. I will not be retaliated against for filing a complaint.	

SECTION 8 - SIGNATURES

By signing, I confirm I have read this form, or had it read to me, and I understand it.

Client

Signature	Printed name	Date

Parent / legal guardian / authorized representative (if applicable)

Signature	Printed name	Date

If signed by a representative, describe authority (parent of minor, legal guardian, health care agent, POA)

Witness (RTFNetwork staff)

Signature	Printed name	Date

Minors: Under Maryland law, a minor who consented to their own substance use disorder treatment, or to mental health treatment at age 16 or older, must sign for release of those records. A parent or guardian signature alone is not sufficient for those records.

NOTICE TO RELEASING PARTY

Prohibition on redisclosure (42 CFR 2.32): If you release Part 2 SUD records, attach the required Part 2 redisclosure notice. Send only the minimum information necessary for the purpose in Section 5. Send records to RTFNetwork, ATTN: Records, by fax to 410.994.4598 or email to documents@rtfnetwork.com; please call 443.429.1985 to confirm receipt.

RTFNetwork office use only

Date request sent	Sent by (staff name)	Method (fax / email / mail)
Date records received	**Received by**	**Date revoked (if applicable)**

Copy given to client: Yes Declined