Active Assailant Interdisciplinary Work Group

How to Use this Document:

This document is a template and should be modified to fit the specific needs of each jurisdiction, as appropriate. Feel free to use the text of this document on your organization's letter head or another appropriate template. Highlighted text appears in brackets throughout the document [Update text] and should be removed and replaced with the appropriate information for your jurisdiction.

Release for Coordination of Care Authorization

This form should be updated annually

Name: ______________________________ Date of Birth: ____________________

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. This request will go to the agency or program's Medical Record or Health Information Department for processing. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate, and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

Yes	No	Provider/Agency Name	Yes	No	Provider/Agency Name
❒	❒	**Crisis Response System Services:** including mobile visits, phone contacts, interventions	❒	❒	**Shelters:** [Insert shelter names]
❒	❒	**[Insert jurisdiction] Core Service Agency**	❒	❒	**Mental Health Provider:** [Insert major mental health providers]
❒	❒	**Police Department:** [Include State and local entities]	❒	❒	**Residential Rehabilitation Program:** [Insert names]
❒	❒	**Fire Department:** [Include county and municipalities as appropriate]	❒	❒	**Case Management/Psychiatric Rehabilitation Program:** [Insert names]
❒	❒	**Hospitals:** [Insert names of regional hospitals]	❒	❒	**Developmental Disabilities Association**
❒	❒	**Emergency Contact:**	❒	❒	**[Insert Jurisdiction] Department of Aging**
❒	❒	**[Insert Jurisdiction] Department of Health**	❒	❒	**[Insert Jurisdiction] Department of Social Services**
❒	❒	**[Insert Jurisdiction] State's Attorney**	❒	❒	**School:**
❒	❒	**Maryland Office of the Public Defender**	❒	❒	**[Insert Jurisdiction] Department of Juvenile Services**
❒	❒	**Crisis Beds:** [Insert names]	❒	❒	**Detention Facilities:** [Insert names]
❒	❒	**SUD Provider**: [Insert names]	❒	❒	**[Insert Jurisdiction] Parole, Probation & Pretrial**
			❒	❒	**Secret Service, Federal Bureau of Investigation, National Security Agency**
❒	❒	**SUD Housing:** [Insert names]	❒	❒	**Other:**

Updated [Insert Date]

INFORMATION REGARDING THE ABOVE-NAMED INDIVIDUAL FOR THE PURPOSE OF:

Coordination of Care and Entitlement Eligibility

INFORMATION RESTRICTED TO: Attendance, services received, adherence with recommendations, diagnosis, medications and side effects (if clinically necessary) with individual treatment plans, testing results, applications, previous providers, treatment plans, discharge summaries, and after care plans.

This permission expires automatically at the end of one year unless otherwise stated but may be revoked by the patient's written request at any prior time except to the extent that action has been taken on it. Parent or legal guardian must sign in the case of a minor child (under age 16 for outpatient mental health services and under 18 for other medical and health services) unless an otherwise minor child is emancipated, or permission is not necessary due to protection under the Minor Right Law.

BEFORE SIGNING - PLEASE READ CAREFULLY AND ASK QUESTIONS IF YOU HAVE ANY:

Patient/Parent/Guardian Signature: ______________________ Date: ________

Witness Signature: ______________________ Date: ________

Agency Completing This Form: ______________________ Date: ________

Release Valid Through: ______________________