Service Provider Release of Information Agreement

Consumer Name: _____

Medical Assistance #:_____ **Date of Birth:** _____

The above-named Consumer has been approved for Behavior Health Services with The WIN Team, LLC.

In an effort to ensure continuity of therapeutic/rehabilitative services and high-quality service collaboration, the following service providers:

The WIN Team, LLC
Located at 4640 Edmondson Avenue; Baltimore, MD 21229 OR 10001 Derekwood Lane, Suite 210

AND

_____

Name of Service Provider: _____

Name of Authorized Representative: _____

Mailing/Office Address: _____

Phone: _____

Email: _____

Fax:

Agree to release and obtain Protected Health Information (PHI) for the above-mentioned Consumer. All PHI released or obtained is for the purpose of assessment and rendering treatment services. We agree to handle all disclosed information confidentially, as outlined by the Federal Health Insurance Portability and Accountability Act (HIPAA) and Maryland's Confidentiality of Medical Records Act (MCMRA).

This agreement is effective from Intake **to** Discharge **for the above-named Consumer.**

_____ _____
Signature of Consumer and/or Guardian **Date**

_____ _____
Signature of Authorized WIN Team Representative **Date**

_____ _____
Signature of Authorized Service Provider **Date**