



GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF BEHAVIORAL HEALTH

Authorization to Use or Disclose Protected Health Information  
(including mental health information and alcohol/drug treatment and prevention information)

Name of Consumer (print) \_\_\_\_\_ Identification Number \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Other name(s) used \_\_\_\_\_

<u>RELEASE INFORMATION TO:</u>	<u>INFORMATION TO BE RELEASED BY:</u>
Name/Title _____	Name/Title _____
Organization _____	Organization _____
Address _____	Address _____
Phone #: _____ Fax # _____	Phone # _____ Fax # _____

**INFORMATION TO BE DISCLOSED:** I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of my clinical records. This includes specific permission to release all records and other information regarding my treatment, hospitalization, and outpatient care including: *(The following items must be checked in order to be released)*

- Drug abuse, alcoholism or other substance abuse;
- Records which may indicate the presence of a communicable or non-communicable disease, and tests for records of HIV/AIDS.

**Limitations for Release:**

- Only for dates of service from \_\_\_\_\_ to \_\_\_\_\_
- Exclusions *(must list if there are any exclusions)* \_\_\_\_\_
- Only the following: *(must list specific documents if applicable)* \_\_\_\_\_

**INFORMATION TO BE USED FOR THE FOLLOWING PURPOSE(S) (List):** \_\_\_\_\_

**EXPIRATION:** This authorization will expire 365 days from the date this form was signed unless one of the following is checked, in which case it will expire on the earliest date:

- On \_\_\_\_\_ (cannot be more than 365 days from the date of this form).
- On \_\_\_\_\_ when: \_\_\_\_\_ occurs.  
*(Date required) (identify specific event)*

**RIGHT TO REVOKE:** I understand that I may revoke this authorization at any time by giving written notice to the organization that was authorized to release this information. I understand that revocation of this authorization will *not* affect any action by the organization that was authorized to release this information before it received my written notice of revocation. I understand that my right to revoke this authorization may be limited if the purpose of this authorization involves applying for health or life insurance.

**OTHER RIGHTS:** I understand that this information cannot legally be redisclosed by the person or organization that received it without my authorization, except as allowed by law.

I understand that I have the right to inspect my record of protected health information. I also understand that I cannot be denied enrollment or services if I decide not to sign this form. However, I may not be able to apply for benefits or renewal of benefits that would help pay for these services.

**SIGNATURE OF CONSUMER OR PERSONAL REPRESENTATIVE:**

I, \_\_\_\_\_, understand that, by signing this form, I am authorizing the use and/or disclosure of the protected health information identified above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print full name \_\_\_\_\_

**AUTHORITY TO ACT ON BEHALF OF CONSUMER (check one):**

Self \_\_\_\_\_ Parent \_\_\_\_\_ \*Personal Representative \_\_\_\_\_ (includes legal guardian and power of attorney)

Other \_\_\_\_\_ (must specify): \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

*\*Supporting documentation required for a personal representative. Attach copy to this form.*

**SIGNATURE OF MINOR:** If the consumer is at least 14 years of age, but under 18 years of age, this authorization is not valid unless the consumer signs in addition to the parent/legal guardian/other personal representative. A minor of any age may authorize disclosure based on his or her signature alone, if (1) he or she is an emancipated minor, or (2) he or she is receiving treatment or services without a parent or legal guardian giving consent.

Signature of Minor \_\_\_\_\_ Date \_\_\_\_\_

Print full name \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

**VERIFICATION OF IDENTITY OF CONSUMER OR PERSONAL REPRESENTATIVE PROVIDING CONSENT IS REQUIRED.**

- Personal identification (government issued photo ID) *Attach a copy.*
- Government official or Department of Behavioral Health provider's oral representation.

\_\_\_\_\_  
*State what you were told and why your reliance on it was reasonable in the circumstances.*

If form is mailed in, the signature on the form must be notarized or the person who is providing consent must have his/her signature notarized or attach a copy of his/her government issued ID.

**I Have Verified the Identity of the Person Providing Consent.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_

**I Revoke this Authorization Effective:** \_\_\_\_\_ **Signature** \_\_\_\_\_  
(Date) (Consumer, or personal representative and relationship to consumer)

**TO THE RECORDS CUSTODIAN:**

1. Provide a copy of this authorization to the consumer or personal representative.
2. Put signed original in the consumer's clinical record.
3. Log this authorization or forward to the Privacy Officer or designee for logging.
4. Send a copy of this form with the information to be disclosed.