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/Client (print) _____ **Identification Number**

Address _____ **Date of Birth**

City/State/Zip Code _____ **Other Name(s) Used**

RELEASE INFORMATION TO:	**INFORMATION TO BE RELEASED BY:**
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 in three hundred and sixty-five (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 three hundred and sixty-five (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/CLIENT 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.

Full Name (Print) _____

Signature _____ Date _____

AUTHORITY TO ACT ON BEHALF OF CONSUMER/CLIENT (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/client is at least fourteen (14) years old, but under eighteen (18) years old, this authorization is not valid unless the consumer/client signs in addition to the parent, legal guardian or 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.

Full Name (Print) _____ DOB _____ Phone # _____

Address: _____

Signature of Minor _____ Date _____

VERIFICATION OF IDENTITY OF CONSUMER/CLIENT 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 under 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 or her signature notarized or attach a copy of his or her government issued ID.

I Verified the Identity of the Person Providing Consent

Full Name (Print) _____ Title _____

Signature _____ Date _____

I Revoke this Authorization Effective: _____ **Signature** _____
(Date) *(Consumer/Client, or personal representative and his or her relationship to the consumer/client)*

TO THE RECORDS CUSTODIAN:

1. Provide a copy of this authorization to the consumer/client 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.