GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health

Addiction Prevention and Recovery Administration

REQUEST FOR RELEASE OF INFORMATION / AUTHORIZATION

Purpose: To obtain authorization for the release and disclosure of PHI. Also, to document the verification of the identity and authority of a person or entity you wish to disclose the PHI.

☐ **Client** ☐ **Third Party** ☐ **Courts** ☐ **Other**_____

☐ **Payment: Purpose is to obtain information regarding insurance coverage for substance abuse treatment that may be available under my insurance plan.**

(*Required field)

*Effective Date: _____/_____/_____ *Expiration Date: ____/____/____

Section A: Client Information *Identification Number: _____

*Name: _____

*Address:_____

City_____State_____ZIP code_____

Telephone: _____ Fax:_____ E-mail_____

*DOB:_____/_____/_____ *Gender: Male ☐ Female ☐

Legal Personal representatives signing on behalf of the individual must complete the following:

Legal Personal Representative's Name:

_____

*Address:_____City:_____State:_____ZIP code_____

Authority to Act as Personal Representative: _____ Telephone:_____

Section B: Recipient/Requester Information: Name and Address of Person ***and*** Entity to whom the Protected Health Information is to be disclosed:

*Name:_____

Company, Organization or Government Agency with which the person claims affiliation: _____

_____

*Address: _____

City_____State_____ZIP Code_____

Telephone:_____ Fax:_____ E-mail:_____

Section C: Release Authorization

I understand that my records are protected under the federal regulations regarding Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action or actions have been taken in reliance on it, and that in any event, this consent expires automatically as follows:

_____

(Give the date, and as needed, the specifics of event or condition when this consent expires)

I authorize the Addiction Prevention and Recovery Administration (APRA) to disclose to the party as named in *Section B: Requestor Information*. I also understand that this information cannot be redisclosed without my written authorization.

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978 (Act). Disclosures may only be made pursuant to a valid authorization by the client, or as provided in Titles III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

Client Signature:_____ Date: _____

Section D: Disclosure Information

*Protected Health Information to be Disclosed: _____

_____

*Purpose of the Disclosure: Describe the purpose for disclosing the protected health information, or attach a copy of any written request or information.

_____

_____

How did you verify the recipient's identity and authority?

_____

Repetitive Disclosure:

☐ Check if this disclosure is one of a series of repetitive accountable disclosures for a single purpose to the same person or entity.

_____

Signature of Staff Member making disclosure: _____

Print name: _____ Title: _____

Date: _____

Recommendation: _____

_____

Section E: Privacy Officer Approval

Privacy Officer Signature: _____ Date: _____

Accept ☐ Deny ☐

Comments: _____

_____

_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include completed form in the individual's records.
Send a copy to the Assistant Privacy Officer and DOH Privacy Officer.