COMMUNITY OF HOPE

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Regarding Patient ***COMPLETE IN FULL (See reverse side for instructions)***

Name – Last, First, MI	Date of Birth - Mo/Da/Yr
Street Address	Telephone #
City	Zip Code

1. Records Released To:

Name (i.e. Health Facility, Physician…)			Name (i.e. Health Facility, Physician…)		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Phone#	Fax#		Phone#	Fax#	

2. Records Requested From:

☐ **COH – CHRC**
4 ATLANTIC ST, SW
Washington, DC 20032
(Phone) 202-540-9857
(fax) 202-232-8494

☐ **COH – FHBC**
801 17TH ST, NE
Washington, DC 20002
(phone) 202-540-9857
(fax) 202-396-6953

☐ **COH – Marie Reed**
2150 CHAMPLAIN ST, NW
Washington, DC 20009
(phone) 202-540-9857
(fax) 202-232-8494

☐ **COH – Commons**
2375 ELVANS RD., SE
Washington, DC 20020
(phone) 202-540-9857
(fax) 202-232-8494

☐ These records are needed for an appointment on ____________________

3. INFORMATION TO BE RELEASED: (Check all applicable categories)

☐ **Complete Copy of All Records** (meaning every page of my record,. This may include, but is not limited to consult notes, reports, correspondence, lab results, social worker records, HIV/AIDS related tests or treatment, developmental disabilities, drug treatment/evaluation, sexually transmitted disease treatment, alcohol treatment/evaluation.)

☐ Allergy Records
☐ X-Ray Reports/Films
☐ Lab Reports
☐ Immunization Records
☐ Substance Abuse Referrals
☐ Behavioral Health Treatment Plan
☐ Behavioral Health Written Letter
☐ Request for Behavioral Health Provider, Verbal Discussion for Care Coordination
☐ **Other:** ____

4. EFFECTIVE PERIOD

The request is for records covering the period:______________________________to______________________________

5. PURPOSE OR NEED FOR DISCLOSURE: (Check all applicable categories)

☐ Further Health Care
☐ Legal
☐ Insurance/Claims
☐ Personal
☐ Application for Insurance
☐ Employment
☐ Disability
☐ Other

**** PLEASE SEE REVERSE FOR FURTHER INFORMATION ****

6. I understand that this authorization will expire on _______________, 20_____; or when the following occur______________. If left blank, this authorization will expire in one year and may be revoked upon receipt of a written request.(See reverse details).

7. I authorize release of my health records in accordance with the specifications listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

8. Signature of patient/signee: ______________________________________ Date____________________

9. Printed name of patient/signee & relationship to patient:____

Notice: In case of substance abuse referrals, Federal regulations (42 CFR Part 2), which have the force of law, prohibit redisclosure of this information without *specific written consent* of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose. In the case of other referrals, disclosure of records generally cannot occur except with the written consent of the client or by court order. However, some disclosures may occur without prior consent in the circumstances specified by federal, state, and local laws, and regulations including Community Regulations governing the rights of program clients. The confidentiality of this client-clinician relationship is subject to those laws and regulations.

Additional Information and Instructions Regarding the Authorization of Use and Disclosure of Protected Health Information

Community of Hope Health Services honors a patient's rights to confidentiality of health information as provided under federal and local law. Please read the following guidelines before signing this authorization. For further details, refer to our Notice of Privacy Practices, available in our offices or on our website at www.communityofhopedc.org.

This authorization is invalid unless it is completed in its entirety. Please review the patient information and each of the eight (8) items listed.

Right to Revoke. You have the right to revoke this authorization any time prior to its expiration by submitting a written request to the Privacy Officer, Community of Hope, at 4 Atlantic St. SW, Washington DC 20032. Your revocation will go into effect immediately upon receipt by the Privacy Officer. However, your written revocation will not affect any disclosures already made in accordance with this authorization before the time you revoke it. Also, if this authorization was obtained as condition for obtaining insurance coverage, your revocation may not be effective in certain insurance claim pursuits (per Title 45 Part 164, Section (b)).

No Obligation. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, COHHS health service providers *may not condition treatment or other health care services* on your agreement to sign this form. Providers request the information that they need to make informed, professional decisions about your treatment or to verify your health history. You may make this request more restrictive by selecting the "other" option under the **information to be released** section.

Re-disclosure. If the person(s) and/or organization(s) authorized by this form to receive your health information are not health care providers or other persons subject to federal health privacy laws ("covered entities"), the health information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your health information without your prior permission.

Signatures. Generally, if you are 18 years of age or older, you are the only person permitted to sign a form to authorize disclosure of your health information. If the patient is under the age of 18, a parent or guardian must sign for the patient. However, there are situations in which this general rule does not apply. For more information about who is authorized to sign this form, contact the Privacy Officer, Community of Hope Health Services.

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit from making further disclosures of this information without the specific consent of the patient or legal representative involved.