AUTHORIZATION FOR REQUEST OF HEALTH RECORDS

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

HIM/Medical Records Department CHRC
4 ATLANTIC ST, SW
Washington, DC 20032
Phone: 202-407-7747
Fax: 202-232-8494

Patient **COMPLETE IN FULL**

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

1. Records Requested From:	**2. Records Released/Disclosed 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#

3. PURPOSE OR NEED FOR DISCLOSURE: (Check all applicable categories)	**4. INFORMATION TO BE RELEASED:** (Check all applicable categories)
☐ Further Health Care ☐ Legal purpose ☐ Insurance/Claims ☐ Personal ☐ Disability ☐ Other________________ ____________________ ☐ Application for Insurance ☐ Employment ☐ For an appointment on ______________	☐ **All Records** -Labs, STD's, Office notes, Medication list, etc. ☐ Labs/date__________ ☐ Allergy Records ☐ Other______________ ☐ Behavioral Health Record ☐ Behavioral Health Written Letter ☐ X-Ray results/Dates_______ ☐ ImmunizationRecords ☐ Medication List ___________________________

5.Release of Substance Abuse Treatment

Release to: ____

Phone number: ____

Fax number: ____

Information to be released: (please be specific) ______________________________

____

____

Dates: ____

Purpose of release: ____

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.

6. EFFECTIVE PERIOD
The request is for records covering the period_______________________________to______________________________________

7. I understand that this authorization will expire on___, 20 ___ or when the following ____
If left blank, this authorization will expire in one year and may be revoked upon receipt of a written request. (See reverse details).

8. 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.

9. Signature of patient/signee:____Date:______________________________

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

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 inour 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 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 inaccordance 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 orto 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 tosign 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.