HIPAA AUTHORIZATION TO RELEASE PERSONAL INFORMATION

Request for release of information FROM DBHIDS to outside agencies or individuals

City of Philadelphia
DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

I authorize DBHIDS to disclose individual information as described below from the records of:

Print full name of consumer whose records are being disclosed

Reason for Disclosure. (Describe each specific purpose. If disclosure is at the individual's request and information to be disclosed *does not include* drug and alcohol treatment information, the reason may state, "at the request of the individual.")

PART A – GENERAL INFORMATION

A-1 Information to be Disclosed. Identify specifically the information to be disclosed. (Section B relating to mental health, drug and alcohol, and HIV-related information must be completed as well.)

A-2 Print **name or title** of the individual/organization to which the information identified in A-1 is to be disclosed.	Print **address** of the individual/organization to which information is to be disclosed.

A-3 This authorization expires as indicated:

- ◉ Once acted upon
- ○ Other (specify date or event)

If left blank or if no date is specified, this authorization will automatically expire 90 days from the date signed.

PART B – SPECIAL CATEGORIES OF MEDICAL INFORMATION (Sections B-1, B-2, and B-3 must be completed)

B-1 Drug and Alcohol Information. If my medical record includes drug and alcohol information, I want to send that information to the individual/organization identified in Part A of this form.

- ◉ Yes
- ○ No, or Not Applicable

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

B-2 Mental Health Information. If my medical record includes mental health information, I want to send that information to the individual/organization identified in Part A of this form.

- ○ Yes
- ○ No, or Not Applicable

B-3 HIV/AIDS Information. If my medical record includes HIV/AIDS information, I want to send that information to the individual/organization identified in Part A of this form.

- ◉ Yes
- ○ No, or Not Applicable

This information will be disclosed from records protected by Pennsylvania law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

PART C – HIPAA AUTHORIZATION SIGNATURES

I understand that:

a. This authorization may be revoked at any time by writing to DBHIDS, except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

b. Information (except drug and alcohol information) disclosed pursuant to this authorization may be subject to re-disclosure by the individual/organization identified in section A-2 above and is no longer protected by federal privacy regulations.

c. I understand that I may inspect or copy my personal health information and may refuse to sign this authorization. DBHIDS will not condition treatment, payment, enrollment, or eligibility on the provision of this authorization.

Signature of Consumer or Personal Representative	*Date of Signature*
Printed Full Name of Consumer	*Date of Birth*

If signed by personal representative, print name of representative, and describe the representative's authority to act for consumer.

Printed Name of Personal Representative	*Date of signature*

Authority to Act for Consumer

_____ *Signature of Witness*	*Date of Signature*

If individual is physically unable to sign and gives verbal consent, signature of second witness is required.

_____ *Signature of Second Witness*	*Date of Signature*

I have been offered a copy of this authorization and have (select one)

○ Accepted the copy

○ Rejected the copy

REVOKE AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby revoke my prior authorization for disclosure of my health information and have provided the original of this revocation to DBHIDS.

_____ *Date of Signature*

Signature of Consumer or Personal Representative

_____ *Date of Signature*

Signature of Witness

If you have questions with your Request for Protected Heath Information (PHI) contact DBHIDS HIPAA by:

Email: DBHIDS.HIPAA@Phila.gov

Mail: **DBHIDS HIPAA**
1101 Market Street, 7th Floor
Philadelphia, PA 19107-2907

Fax: **(215) 685-4684**