



**AUTHORIZATION FOR DISCLOSING AND/OR REQUESTING PROTECTED HEALTH INFORMATION**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Client Case Number: \_\_\_\_\_

**Henrico Area Mental Health and Developmental Services is hereby authorized to:**

- Request From
- Disclose To
- Request From and Disclose To

**Name of Treating Provider/Insurance Company/Other Entity:**

**Name of Individual:**

Relationship to client (optional):

Address:

City/State/Zip:

Phone:

Fax Number:

**Description of Information to Request and/or Disclose:**

- |  |   |
|--|---|
| <input type="checkbox"/> Evaluation/Assessment               | <input type="checkbox"/> Psychological Evaluation                         |
| <input type="checkbox"/> Medication(s) Prescribed            | <input type="checkbox"/> Treatment  |
| <input type="checkbox"/> General Physical Health             | <input type="checkbox"/> Infectious Disease: AIDS, HIV, TB, Other         |
| <input type="checkbox"/> Information related to an emergency | <input type="checkbox"/> Case Closing Summary                             |
| <input type="checkbox"/> Financial Information               | <input type="checkbox"/> Photographs, videotapes, digital or other images |
| <input type="checkbox"/> Other, specify:                     |   |

**Substance Use Information (disclosure must be limited to that information which is necessary to carry out the stated purpose):**

- All of my substance use information created by HAMHDS
- All of my substance use information received from other treatment providers
- None of my substance use information

**OR only the following substance use information:**

- Substance Use Diagnosis
- Medications for Substance Use
- Lab Results related to Substance Use
- History of Substance Use
- Participation in services for Substance Use

**Purpose of Request and/or Disclosure:**

- |  |   |
|--|---|
| <input type="checkbox"/> Assessment                  | <input type="checkbox"/> Coordination of care     |
| <input type="checkbox"/> Payment for HAMHDS services | <input type="checkbox"/> Emergency contact        |
| <input type="checkbox"/> Court-ordered evaluation    | <input type="checkbox"/> At request of Individual |
| <input type="checkbox"/> Other, Specify:             |   |

**This authorization is effective on the date client or client representative signature is obtained and will expire:**

- 365 days after discharge from agency or  in 365 days



**AUTHORIZATION FOR DISCLOSING AND/OR REQUESTING PROTECTED HEALTH INFORMATION**

Client Case Number: \_\_\_\_\_

As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations or eligibility are not conditional upon giving authorization. The original or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. I understand that, upon my request, I must be provided a list of entities to which my information has been disclosed.

There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by federal confidentiality rules (42 CFR part 2), the federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by your written authorization 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 patient with a substance use disorder.

**Person authorizing disclosure/request is:**

- Client       Parent of Minor Child       Legal Guardian       Power of Attorney
- Authorized Representative

If other than client, name:

Client Signature	Date Signed
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Client's Personal Representative Signature	Relationship to Client Parent of Minor, Legal Guardian, Power of Attorney, Authorized Representative	Date Signed
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