



Authorization to Permit Release of Health Information

ONE-TIME RELEASE

1. Patient or Authorized Representative:

Date of request:	Month:	Day:	Year:
First Name:	Middle Initial:	Last Name:	
Preferred Name:			
Date of Birth:	Month:	Day:	Year:
Street Address:			
Apt. No.:	City:	State:	Zip:
Records should be: <input type="checkbox"/> Mailed to the above address <input type="checkbox"/> Mailed/Faxed to the agency selected in section 3 <input type="checkbox"/> Left at WWH/Pick Up: <input type="checkbox"/> 1525 <input type="checkbox"/> MRC			
Daytime Phone:		Email Address:	

2. I am requesting that my health information be released from at least one of the following:

<input type="checkbox"/> Georgetown University Hospital <input type="checkbox"/> George Washington University Hospital <input type="checkbox"/> Howard University Hospital <input type="checkbox"/> Holy Cross Medical Center	<input type="checkbox"/> INOVA Health Systems <input type="checkbox"/> Providence Hospital <input type="checkbox"/> Sibley Memorial Hospital <input type="checkbox"/> Southern Maryland Hospital	<input type="checkbox"/> United Medical Center <input type="checkbox"/> Washington Hospital Center <input type="checkbox"/> Whitman-Walker Health <input type="checkbox"/> Whitman-Walker Health Legal Services
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OR Individual/Entity/Organization not listed above:

Name:		
Street Address:		
City:	State:	Zip:
Phone:	Fax:	Email:
Date the Information is needed by: ____/____/____	Preferred Format: <input type="checkbox"/> Paper <input type="checkbox"/> Thumbdrive <input type="checkbox"/> CD <input type="checkbox"/> Email	

3. I am requesting that my health information be sent to:

<input type="checkbox"/> Georgetown University Hospital <input type="checkbox"/> George Washington University Hospital <input type="checkbox"/> Howard University Hospital <input type="checkbox"/> Holy Cross Medical Center	<input type="checkbox"/> INOVA Health Systems <input type="checkbox"/> Providence Hospital <input type="checkbox"/> Self/Patient <input type="checkbox"/> Sibley Memorial Hospital	<input type="checkbox"/> Southern Maryland Hospital <input type="checkbox"/> United Medical Center <input type="checkbox"/> Washington Hospital Center <input type="checkbox"/> Whitman-Walker Health <input type="checkbox"/> Whitman-Walker Health Legal Services
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OR Individual/Entity/Organization not listed above:

Name:		
Street Address:		
City:	State:	Zip:
Phone: _____	Fax: _____	Email: _____
Date the Information is needed by: ____/____/____	Preferred Format: <input type="checkbox"/> Paper <input type="checkbox"/> Thumbdrive <input type="checkbox"/> CD <input type="checkbox"/> Email	

4. Reason(s) for release of information:

<input type="checkbox"/> Continuity of Care <input type="checkbox"/> Disability application or appeal <input type="checkbox"/> Employment <input type="checkbox"/> Legal Gender Marker Change	<input type="checkbox"/> Legal Representation <input type="checkbox"/> Medical Appointment <input type="checkbox"/> Personal <input type="checkbox"/> School	<input type="checkbox"/> Transfer of Care <input type="checkbox"/> Verification of Status <input type="checkbox"/> Other (Specify): _____ _____
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ONE-TIME RELEASE (CONTINUED)

5. Information to be released:

<input type="checkbox"/> 719A Form	<input type="checkbox"/> Insurance Forms	<input type="checkbox"/> Metro Access Forms
<input type="checkbox"/> Gender Marker Form	<input type="checkbox"/> Medicaid/IDA Disability Forms*	<input type="checkbox"/> Social Security Disability Forms
<input type="checkbox"/> Letter regarding treatment (Describe): _____		

* WWH has a public benefits department that can assist you with all public insurance options, including Medicaid, ADAP, and MADAP

OR to only release specific portions of your health information, indicate the categories to be released:

<input type="checkbox"/> All Medical Records	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Medications
<input type="checkbox"/> Billing Records	<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Other information or instructions: _____		

Your medical record may contain information that is afforded a higher level of confidentiality.

WWH will not release the records described above unless you INITIAL THE BLOCK next to the type of information you wish to be released:

HIV information _____ Drug/Alcohol Treatment information _____ Mental/Behavioral Health information _____

I decline to initial above _____ If the above section does not apply to you, initial here: N/A _____

6. Health Information includes written and verbal information:

By initialing here _____, you acknowledge that the release of your health information can be released in a written/and or verbal format.

7. I understand that:

Whitman-Walker Health will not deny me treatment because I refuse to sign this Authorization. I understand that I may revoke this Authorization at any time by submitting a written request to WWH unless Whitman-Walker Health has already taken action based on this Authorization, or unless this Authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy.

This authorization will remain in effect for a one year period (from the date of my signature below), unless revoked by me prior to my information being released.

The information disclosed based on this Authorization may be re-disclosed by the entity or the person who received the information. Once disclosed, it is possible that the information will no longer be protected under Federal or State privacy laws.

I may inspect or copy the medical information that is being released, used and/or shared pursuant to this Authorization Form.

The use or disclosure of information obtained or released pursuant to this Authorization may result in direct or indirect payment to WWH or a third-party, including copying fees.

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act. Disclosures may only be made in compliance with the Act. The Act provides for civil damages and criminal penalties for violations (D.C. Code § 6-2004 (1995)).

If the records or information being released involve treatment for alcohol or substance addiction, my records are also protected by Federal law and regulations relating to "confidentiality of alcohol or drug abuse patient records," (42 C.F.R. Part 2, 42 U. S. C. § 290dd-2).

There may be a charge for the requested records.

8. Patient's Signature

By signing this form, I acknowledge that I have read and understand the contents of this form:

Patient or Representative:	Date:
Relationship to Patient (If requestor is not the patient):	

WWH understands the importance of your request and strives to process it as soon as possible in the order in which your request was received. Please complete the "information needed by" section of this form to indicate if the requested information is needed by a specific date and every effort will be made to meet your needs. Please keep in mind that under HIPAA, WWH has thirty (30) days to process requests.

Notice to Individual or Entity Authorized to Receive Alcohol or Substance Abuse Addiction Records

Pursuant to This Notice: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2) relating to the confidentiality of alcohol and substance abuse records. Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 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 also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client of WWH.