WHITMAN-WALKER HEALTH

Authorization to Permit Release of Health Information

ONE-TIME RELEASE

1. Patient or Authorized Representative: Please fill in Section 1 Below

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: ☐ Mailed to the above address ☐ Mailed/Faxed to the agency selected in section 3 ☐ **Left at WWH/Pick Up:** ☐ 1525 ☐ MRC					
Daytime Phone:				**Email Address:**	

2. I am requesting that my health information be released from at least one of the following: Not Applicable

☐ Georgetown University Hospital	☐ INOVA Health Systems	☐ United Medical Center
☐ George Washington University Hospital	☐ Providence Hospital	☐ Washington Hospital Center
☐ Howard University Hospital	☐ Sibley Memorial Hospital	☐ Whitman-Walker Health
☐ Holy Cross Medical Center	☐ Southern Maryland Hospital	☐ Whitman-Walker Health Legal Services

OR Individual/Entity/Organization not listed above:

Name:		
Street Address:		
City:	**State:**	**Zip:**
Phone:	**Fax:**	**Email:**
Date the Information is needed by:	**Preferred Format:** ☐ Paper ☐ Thumbdrive ☐ CD ☐ Email	

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

☐ Georgetown University Hospital	☐ INOVA Health	☐ Southern Maryland Hospital
☐ George Washington University Hospital	☐ Systems Providence Hospital	☐ United Medical Center
☐ Howard University Hospital	☐ Self/Patient	☐ Washington Hospital Center
☐ Holy Cross Medical Center	☐ Sibley Memorial Hospital	☐ Whitman-Walker Health
		☐ Whitman-Walker Health Legal Services

OR Individual/Entity/Organization not listed above:

Name:		
Street Address:		
City:	**State:**	**Zip:**
Phone:_____	**Fax:**_____	**Email:**_____
Date the Information is needed by:	**Preferred Format:** ☐ Paper ☐ Thumbdrive ☐ CD ☐ Email	

PLEASE FAX THIS DOCUMENT TO 202-332-1049

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ONE-TIME RELEASE (CONTINUED)

4. Reason(s) for release of information:

☐ Continuity of Care	☐ Legal Representation	☐ Transfer of Care
☐ Disability application or appeal	☐ Medical Appointment	☐ Verification of Status
☐ Employment	☐ Personal	☐ Other (Specify):
☐ Legal Gender Marker Change	☐ School	

5. Information to be released:

☐ 719A Form	☐ Insurance Forms	☐ Metro Access Forms
☐ Gender Marker Form	☐ Medicaid/IDA Disability Forms*	☐ Social Security Disability Forms
☐ 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:

☐ All Medical Records	☐ Immunizations	☐ Medications
☐ Billing Records	☐ Laboratory test results	☐ Progress Notes
☐ 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:_____

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.

If I am authorizing the release of mental/behavioral health information, 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.

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Authorization to Permit Release of Health Information

ONE-TIME RELEASE (CONTINUED)

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.