Washington D.C. Authorization for Use and Disclosure of Private/ Protected Health Information

I. **Identification of person authorizing release** (The following is needed for verification. Please complete all applicable items.):

Name of Member/Participant/Patient: _____

Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number(s): (Home): _____ (Work): _____ (Cell): _____

Fax number: _____

E-mail address: _____

Please tell us how you would like us to communicate with you. (Check all that apply.)

☐ Email ☐ Letter ☐ Telephone

Name of Insurance Company: _____

Member ID card number: _____

Group or Account Number on ID card: _____

Subscriber's (Employee) name (if different from Participant's): _____

Subscriber's relationship to Participant: _____

Subscriber's Employer Name: _____

If you have dual coverage, please complete the following information as well:

Subscriber's Employer Name: _____

Number on Participant ID card: _____

Group or Account Number on ID card: _____

II. Description of Private Health Information to be Released

Describe what information you are authorizing to be released. Describe in detail the kind of information (e.g. claims information, premium information, medical records including test results, etc.) you want released, and if applicable, the date(s) of the information (e.g. claims for the last 6 months, premium payment record for January). Please include the names and address of providers from whom information should be obtained. Use a separate sheet if necessary.

In addition, if you agree that the following types of information may be released, please indicate so by checking the appropriate boxes:

Psychotherapy Notes*	Mental Health Records*	Genetic Testing Records
HIV/AIDS Records*	Maternity Records	Sexual/physical/mental abuse
Sexually transmitted or other communicable diseases		Alcohol/substance abuse records*

* If this authorization is for psychotherapy notes, this authorization cannot be used for any other type of protected health information. If you want to authorize the use or disclosure of other protected health information as well, an additional form must be submitted.

Who can release and receive the information (limitations on disclosure): Insert the person(s)/company(ies) allowed to release the information and the person(s)/company(ies) allowed to receive the information. The following person(s)/company(ies) are allowed to release the information as requested (Use another sheet if necessary):

The information may be provided to (include name and address):

III. Purpose of this release of information

☐ At the request of the covered individual;

☐ If not requested by the individual, state the purpose of the release of information:

IV. Expiration Date

If not previously revoked, this authorization will terminate on the earliest of the following dates:

a. the date the individual's coverage ends;
b. one year from the signature date below; or
c. upon the following date, event or condition:

V. Signature

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. A copy of this authorization will also serve as the original if multiple disclosures are required. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information described above may be redisclosed by the recipient and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person(s)/company (ies) specified above except to the extent that the person(s)/company (ies) have already taken action on the disclosure provisions contained in this document.

_____ Date:_____
(Signature of adult member **OR** parent on behalf of minor, as applicable)

_____ Date: _____
(Signature of Legal Representative, if applicable)