HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

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

The following recipient who is a:

☐ Treating/Service Provider: Indicate name of treating provider below [ex. PCP, hospital, other treatment provider]

☐ Insurance Company: Indicate name of insurance company below [ex. Anthem Healthkeepers Plus, United Healthcare]

☐ Other Entity: Indicate name of other entity below. **If information is protected by 42 CFR Part 2, indicate both name of entity and name of individual receiving the information.** [ex. Henrico Circuit Court, Judge Smith]

☐ Individual: Indicate name of individual below [ex. family member, friend]

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:

☐Evaluation/Assessment
☐Medication(s) Prescribed
☐General Physical Health
☐Information related to an emergency
☐Financial Information
☐Other, specify:
☐ Psychological Evaluation
☐Treatment
☐Infectious Disease: AIDS, HIV, TB, Other
☐Case Closing Summary
☐Photographs, videotapes, digital or other images

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
☐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

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Client Case Number: _____

Purpose of Request and/or Disclosure:

- ☐Assessment
- ☐Payment for HAMHDS services
- ☐Court-ordered evaluation
- ☐Other, Specify:
- ☐Coordination of care
- ☐Emergency contact
- ☐At request of Individual

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

☐ 30 days after discharge from agency or ☐ in 365 days

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 _____

Client's Personal Representative Signature _____ Relationship to Client _____ Date Signed _____

Parent of Minor, Legal Guardian, Power of Attorney, Authorized Representative