Instructions for Completing the FFCCSB Authorization to Disclose or Request Protected Health Info.

The Authorization and Request form is be used to request copies of records, exchange information, and/or release to or receive records from: family member(s), lawyers, physicians, Probation/Parole Officers, etc.

1. Enter the information of the individual to whom the records pertain.

a. Use the individual's address and client's identification or social security number.
b. Please include an email address, if available
c. Use the individual's phone number(s).
    i. If other than the client's, please identify whose number
    ii. May be used to communicate with individual. i.e., when records are ready for pick up.

2. Choose a box or both, as needed:
Exchange with – Verbal two-way flow of information between the CSB and outside provider/organization/individual
Release to – CSB to outside provider/organization/individual

- The *If sending* line is used when requesting physical records to be sent at the time of form completion. If known, fill in the dates (from - to) for the time period of the records being requested.
- It is acceptable to leave these blank, when/if not requesting records at time of form completion.

3. Enter Provider/Organization/Individual name(s) to whom info is to be released or exchanged with. (If available, include the address and/or phone number)

4. Identify the Information. Check the box(es) that best fits the requested information description.

a. If individual has records that are 42 CFR Part 2 protected, they should check the box for Substance Use Tx Records along with any others that may apply. Otherwise, the content of the record set may be limited.

5. Check the box that best describes the reason for authorizing the release of the selected record set. This form already includes the standard purposes: *treatment, payment, and healthcare operations* as defined in HIPAA 45CFR 164.506: sharingfortpo.pdf (hhs.gov)

- If the purpose is for anything other than the standard; check the box below and please be specific when describing the other purpose.

6. An expiration date or event must be entered into this field.

a. This authorization will be in effect until the date or event entered.

Note: *Events* - must be specific and reflect an accessible "date" . i.e., *30 days after discharge from the CSB*

7. Carefully read over the **redisclosure** rules.

Note: Staff person (usually clinician) should review the ***Understanding and Rights*** section with the individual and/or authorized representative before obtaining their signature.
In #4, if signing as a condition of the individual's criminal status, (if known) enter the date or event the individual may revoke this authorization; if prior to this authorization's expiration date/event.

- If date is unknown, leave blank.

8. If a copy of the designated record set is requested at the time of completion, check the box of the preferred format.

a. Records will contact (using the number(s) provided above), with the amount for the associated copy charges.

9. If requesting a copy of the indicated record set to be sent to a 3rd party entity; fill out the recipient's mailing address, phone #, fax # (if known), and email address.

- **Note: Only Records Dept support staff will use this information to send requested records/info.** There is no charge for records requested by other CSBs, hospitals, doctors, legal aid, or public defender's office. Social Security Administration and Workmen's Compensation pay a flat fee and are not subject to the itemized charges.

10. Individual (CSB client to whom the records pertain) is to sign and date. (This is the date used as the "effective" date of the form) Please obtain a copy of the individual's/CSB Client's ID.

11. If person signing this authorization is other than and/or in addition to the individual, he/she signs the *Other Signature* line, and dates the authorization. This person must check the appropriate signee role box.

a. Please identify your relationship to the individual to whom the records pertain, by checking the appropriate box

- Examples of persons authorized to sign: Court appointed guardian and/or representative authorized by a *Power of Attorney*
- Staff, please be sure to obtain the documentation identifying the Other's authority to sign on individual's behalf.

12. Please include a copy of the signee's ID with this form, if not already obtained and in the EHR. If there's an "*other signee"*, please include a copy of the other signee's ID.

- Be sure to check the boxes to show ID and/or proof obtained.
  - Examples of appropriate "proof" of relationship to client: Notarized POA, Court Orders of Appointment
  - Examples of acceptable IDs: Driver's License, school ID, passport

13. Please enter the name and credentials of staff assisting individual with completing and/or accepting the form, and date.

14. The individual or authorized representative should be offered a copy of the signed authorization.

a. If submitting electronically, the form will need to be sent for signature and a copy will already be provided

Record of Revocation of Authorization

An authorization to an officer of the Criminal Justice System (Probation/Parole) cannot be revoked if the individual's participation in treatment is a condition of his/her criminal justice status.

a. If individual wants to revoke or terminate the authorization before the specified expiration date, staff person must complete the "Revocation of Authorization" form (in Credible) and obtain the individual and/or authorized representative's signature.
   - The notice of revocation must be in writing. If written notice is not received, the authorization will remain effective until it expires.

b. Parties to an authorization will only be notified of the revocation, when/if they are requesting records, based on the authorization.

FAIRFAX - FALLS CHURCH
Community Services Board

Authorization to Disclose or Request Protected Health Information

Client Information Date: _____

Name (Last, First, Middle Initial) | Date of Birth

Street Address, City, ST, Zip Code | Social Security or Patient ID

Primary Phone | Other Phone Number | Email Address

I authorize the Fairfax-Falls Church Community Services Board to:
☐ **Exchange with:** ☐ **Release to:** **If sending records: info is for the time period from** _____ **to** _____

The following organization(s) or individual(s): _____

The following information:
☐ **All information below, OR** ☐ **Only the information checked below:**

☐ Substance Use Treatment Record (42CFR Part2)	☐ Medication History	☐ Progress Notes/Report	☐ Lab Results
☐ Treatment Plans	☐ Diagnosis History	☐ Assessment/Evaluations	☐ Discharge Summary
☐ Account Information	☐ Social History	☐ Administrative Records	☐ Other: _____

☐ **For treatment, payment and healthcare operations, and/or**
☐ **The following purpose** *(must be specific):* _____

This authorization is in effect from the date of signature below to _____
(Date or Event)

Redisclosure:

1. If these records are protected by Federal Substance Use Confidentiality Regulations (42 CFR Part 2), I understand a recipient is prohibited from making any further disclosure of substance use disorder information, and this information may not be used to criminally investigate or prosecute substance use disorder patients, unless otherwise permitted by 42 CFR Part 2.
2. If I am authorizing disclosure of substance use disorder information for the criminal justice system, 42 CFR Part 2 allows individuals within the criminal justice system who receive this information to redisclose it to carry out their official duties.
3. If these records are not protected by 42 CFR Part 2, I understand that information used or disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal HIPAA Regulations.

I understand that:

1. Service providers using or disclosing substance use disorder information based on this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure outlined above.
2. The provision of treatment, payment, enrollment, or eligibility for benefits does not depend on whether I sign this authorization.
3. I may revoke this authorization at any time by submitting a written statement of revocation to one of the CSB staff contacts listed in the CSB's Notice of Privacy Practices, except to the extent that providers already have acted based on this authorization. If I am signing this authorization as a condition of my criminal justice status, this authorization may only be revoked after my criminal matter(s) are concluded or after _____ (Date or Event).
4. The information to be released has been fully explained to me and this authorization is given of my own free will.
5. I have been given a copy of this authorization or a copy has been placed in my file.

If a copy of the designated record set is requested, I understand that I will be charged a fee of $0.37 cents per page up to fifty (50) pages and $0.18 cents per page thereafter, plus $10.00 Administrative fee; to cover the associated copying charge of my record.
I would like my records: ☐ electronically ☐ paper format

The following information is needed if requesting records. Records are to be sent by Records Staff only:
Please send requested records to the following address: _____
Phone #_____ Fax #_____ Email _____

Individual's Signature: _____ Date: _____

Other Signature: _____ Date: _____

Other Signee's Relationship to Client: ☐ Parent of Minor Child ☐ Guardian ☐ Authorized Representative
☐ Proof of Other Signee's Relationship to Client in EHR: _____
☐ Photo ID of signee verified, prior to release of Records
Staff accepting/recording form: _____ (include credentials) Date: _____