Authorization to Disclose or Request Protected Health Information

(HIPAA Compliant Authorization Form)

I, ______________________________ ______________________________ ______________________________
Name of Patient (Please Print) *Patient's Date of Birth (mm/dd/yy)* *Patient's Phone Number*

of ____
Patient's Address

hereby authorize the following Service Provider:
County Agency/Program/Office: ______________________________
Address: ______________________________

1. To ☐ **disclose** individually identifiable health information to and/or ☐ **receive** information on my behalf from:

   ______________________________ or his/her designee ______________________________
   Supervisor/County Official *Name*

2. The following specific information is authorized: ______________________________
   ____

3. This authorization is in effect for the period of time from ______________ to ______________
   (Date or Event) *(Date or Event)*

4. This authorization allows the indicated service provider to share the specified information for:
   ☐A single use or disclosure available at the time of authorization
   ☐On-going use or disclosure for the time period identified in Item 3

5. The information will be used/disclosed for the following purpose(s): ______________________________
   ____

6. The source records for information disclosure:
   ☐ **ARE** protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) because the records contain information on prior, current, or planned substance abuse treatment. If these records are protected by regulation 42 CFR Part 2, I understand the recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted within the regulation. 42 CFR Part 2 also restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.
   ☐ **ARE NOT** protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand the Federal Privacy Rule (45 CFR Part 160 and 164, HIPAA) requires I be advised that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal HIPAA regulations.

7. I understand that:
   - Service providers using or disclosing information based on this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure identified in Item 5.
   - Fairfax County will not condition the provision of services related to treatment, payment, enrollment, or eligibility for benefits on my decision to sign this authorization.
   - I may revoke (or cancel) this authorization at any time by submitting a written statement of revocation to the service provider whose address is provided above, except to the extent that the identified service provider already has taken action based on this authorization.
   - I have a right to request and receive a Notice of Privacy Practices from Fairfax County.
   - The information to be released has been fully explained to me and this authorization is given of my own free will.

8. Please send or communicate the authorized information to the following address, phone number or fax number:

   ____

Resident Signature: ______________________________ Date: ______________

Relationship to patient: ☐ *Self* ☐*Parent of Minor Child* ☐*Guardian* ☐*Legally Authorized Representative*

A copy of this document shall be as valid as the original. *County Official authorization, 10/24/03*