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. **Virginia law does not allow the release of information/records, if any, obtained during the civil commitment process, except to another treating health care provider. Va. Code §§ 16.1-337, 37.2-804.2 and -818.**
2. 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.
3. The provision of treatment, payment, enrollment, or eligibility for benefits does not depend on whether I sign this authorization.
4. 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).
5. The information to be released has been fully explained to me and this authorization is given of my own free will.
6. 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: _____