Fairfax-Falls Church Community Services Board

Authorization to Disclose or Request Protected Health Information

PATIENT INFORMATION

Today's date

Name (last, first, middle initial)

Date of birth

Street address, city, state, ZIP Code

Social Security # or Patient ID

Primary phone number | Other phone number

Email address

I authorize the Fairfax-Falls Church Community Services Board to:

☐ Access / Copy ☐ Exchange ☐ Release

The following information:

☐ Discharge Summary ☐ Medication History ☐ Progress Notes/Report ☐ Lab Results

☐ Treatment Plans ☐ Diagnosis History ☐ Assessment/Evaluations ☐ Other_____

☐ Account Information ☐ Social History ☐ Administrative Records _____

For the following purpose: *(must be specific)* _____

To the following provider/organization/individual: _____

This authorization is in effect for the time period from _____ to _____
(Date or event) *(Date or event)*

This authorization allows the indicated providers to share information described above for:

☐ A single use or disclosure at the time of authorization. ☐ Ongoing use or disclosure during the time period specified above.

These records:

☐ **ARE** protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are protected by 42 CFR Part 2, I understand a recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization; except as otherwise permitted by the Regulations. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. ☐ I authorize the release of these records.

☐ **ARE NOT** protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand that the HIPAA Privacy Regulations require 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.

I understand that:

- **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.**
- 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 outlined above.
- The provision of treatment, payment, enrollment, or eligibility for benefits does not depend on whether I sign this authorization.
- If I am participating in treatment as a condition of my criminal justice status, I must sign an authorization to allow the CSB to exchange information with my Probation/Parole Officer (PO).
- I may revoke (or cancel) 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 the identified service providers already have acted based on this authorization, or if I am participating in treatment as a condition of my criminal justice status.
- The information to be released has been fully explained to me and this authorization is given of my own free will.
- I am entitled to a copy of this signed authorization.

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 pages and $0.18 cents per page thereafter, or $6.00 for a CD, plus a $10.00 administrative fee to cover the associated copying charge of my record. I would like my records: ☐ electronically ☐ paper format

Individual's signature: _____ Date: _____

Other signature: _____ Date: _____

Other signee's relationship to patient: ☐ Parent of Minor Child ☐ Guardian ☐ Authorized Representative

Staff accepting/recording form: _____ (include credentials) Date: _____

Please send requested information to: _____

Phone #_____ Fax #_____ Email _____