DEPAUL
COMMUNITY RESOURCES

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

Type of Release (check one)
☐ One-time exchange of information
☐ Ongoing exchange of information

I, _____ (print full name of person signing form) do hereby authorize and request DePaul Community Resources to use or disclose Protected Health Information regarding (name of Service User) _____.

Service User's current information

Address: _____ **Date of Birth**: _____
_____
_____

Telephone: _____ **Social Security # (opt.): _____**

Information may be exchanged between DePaul Community Resources and the following Person(s), Agency, Organization or Health Care Entity:

Name: _____
Address: _____
_____

Please specify the Protected Health Information to be released by marking the following:

☐ Assessment Information	☐ Psychiatric Records	☐ Discharge Summary
☐ Social History	☐ Psychological Records	☐ Other: _____ (Specify)
☐ Progress Notes	☐ Mental Health Diagnosis	
☐ Educational Records	☐ Medical Records	

The **Purpose** of this disclosure is for:

☐ Service Coordination/Provision of services	☐ Eligibility Determination
☐ At the request of the individual	☐ Other: _____

I understand that:

- Personally Identifiable Information (PII) and other confidential information shared between DePaul, its subcontractors, and referral sources will be handled in accordance with applicable federal and Virginia laws.
- Information will be stored securely in electronic health record systems or, for paper records dated prior to September 1, 2017, in locked physical storage accessible only to authorized personnel.
- Information will be retained by DePaul and its subcontractors for the time period required by the Code of Virginia and other applicable regulations.
- Different agencies and organizations provide different services and benefits. Each must have specific information to provide services and benefits. By signing this form, I am allowing agencies to exchange

certain information, including confidential health records, so it will be easier for them to work together more effectively to provide or coordinate services.

- I can withdraw this Authorization at any time by notifying DePaul in writing.
- Withdrawal of this authorization does not affect any disclosure of Protected Health Information made prior to the receipt of written notice of revocation by the custodian of health records.
- I have the right to see and receive a copy of the information described in this Authorization if I request it in writing.
- My provision of services, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization.
- There is a potential that information disclosed may be re-disclosed by the recipient and no longer protected by law (see note below re: 42 CFR Part 2).
- A copy of this Authorization and a notation concerning the person or agencies to which disclosure was made shall be included with the original health records and I have a right to a copy of this Authorization.
- All information disclosed pursuant to this authorization will be transmitted using secure methods, including encrypted email, secure fax, or other approved secure data transfer methods.
- My substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, and HIPAA, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.
- This authorization will expire on the following expiration event:

☐ **Termination of Services** ☐ **End of Plan Year (Date: _____)**
☐ **Specific Date: _____**

SIGNATURE(S): _____ DATE: _____
(Signature of Service User)

_____ DATE: _____
(Signature of Authorized Representative of Service User, if applicable.)

_____
(Representative Relationship to Service User/Description of Authority to Act/Sign)

_____
(Address and Telephone Number of Service User's Authorized Representative.)

_____ DATE: _____
(Signature of Witness)

_____
(Printed Name of Witness)

NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by this written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.