District of Columbia Government
DEPARTMENT OF CORRECTIONS

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Purpose: This form is used by current or former DOC inmate to authorize DOC and its business associates to disclose PHI described and for the purpose stated herein.

Name: _____

DCDC if inmate _____ SSN if other _____

Facility: _____

PHI to Be Use or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed:

_____

_____

Entities Authorized to Use or Disclose PHI: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including DOC, who you are authorizing to make use of and/or to disclose the protected health information described above:

_____ _____
(Name) (Organization)

_____ _____
(Name) (Organization)

Entities Authorized to Receive PHI: Name of specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including DOC, to whom you are authorizing the disclosure and subsequent use of protected health information described above"

_____ _____
(Name) (Organization)

_____ _____
(Name) (Organization)

_____ _____
(Name) (Organization)

Purpose of this Authorization:

☐ At request of individual

☐ For the following purposes

_____

_____

Effect of Granting this Authorization: The PHI described above may be disclosed to, received by, and further disclosed by persons or organizations that are not health plans, covered health care providers or health care cleannghouses subject to federal health information privacy laws.

Authority: 45 C.F.R. §164.508

Expiration and Revocation:

This authorization will expire (complete one):

☐ On ____/____/____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use And/or disclosure being authorized):

_____

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance of this authorization before you received my written notice of revocation.

Contact Office: _____

Telephone: _____

E-mail: _____

Address: _____

INDIVIDUAL'S SIGNATURE

I, _____ , have had full opportunity to read and consider the contents of this Authorization for the use and/or disclosure of my protected health information, as described in this form.

_____ _____

(Signature) (Date)

If this authorization is being granted by personal representative on behalf of the individual, complete the following :

Personal Representative's Name: _____

Address: _____

Relationship to Individual: _____

Verification of Identity and Authority: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

Include this authorization in the individual's records.
Send copy to the Privacy Official

Authority: 45 C.F.R. §164.508