9.00
APPENDIX 6
AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

The Authorization for Disclosure of Consumer Medical/Health Information (Authorization) is a *statewide* form implemented by multiple state agencies, including the Department of Health and Senior Services (DHSS), in response to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) (PL-111-5) (collectively, and hereinafter, HIPAA). This form serves as written documentation to obtain and/or release protected health information (PHI) as required by HIPAA. PHI is defined as any individually identifiable health information which would include:

- Participant case record information
- Demographic information (name, address, date of birth, etc.)
- Physical and mental health information contained in the case

This form provides maximum protection for the participant's privacy and serves as a legal means of documenting the participant's permission for information sharing. Use of this form also documents what information is released and the purpose of the disclosure. This form shall be completed any time PHI will be released in hard copy form to a person or entity other than the participant, guardian, or other legal representative. It may also be used to document permission to share information verbally, when necessary as outlined in the Confidentiality Requirements policy.

The authorization becomes effective on the date of signature and expires one year from that date unless it is revoked by the participant prior to that time.

INSTRUCTIONS

This form shall be typed or clearly written in ink prior to being signed by the participant.

- **No** blank or partially completed forms are to be signed by the participant.
- DSDS staff completing the form shall review **all** the information contained in the document with the participant

Enter the information on the form as outlined below:

- Enter the name of the person *authorizing* the release of the participant's medical/health information
  - This may be the participant, a legal guardian, or an individual named as a durable power of attorney for health care (DPOA-HC) that has been invoked.
    - If the authorizing individual is not the participant, a copy of the document granting legal authority to act on behalf of the participant must be attached.
    - If the person is deceased, the document granting legal authority would be papers appointing a personal representative.

- Check the appropriate field to indicate the entity providing medical/health information about the participant
  - When using the 'Other' field, enter the name of the specific entity.
- Enter the participant's full legal name, Departmental Client Number (DCN), and date of birth
- Enter the Social Security Number *only if* the participant does not have an assigned DCN

PURPOSE OF DISCLOSURE

The following shall be completed:

- List the specific dates of services included in the requested records
  - The phrase "any and all" is not specific and shall not be used.
- Check the appropriate box to indicate the entity that will receive the information
  - When using the 'Other' box, enter the name of the specific entity and complete the address information.
- Check all applicable purposes for the disclosure.
  - If the boxes provided are not applicable, mark "other" and write in the purpose.
- Check all applicable information to be disclosed
  - When the requested information is not listed, mark other and provide a description of the specific information.

REVIEW OF INFORMATION WITH PARTICIPANT

The information obtained shall be reviewed with the participant.

- Obtain the participant's signature (when there is no legal guardian or DPOA-HC) and enter the date signed
- Obtain the witness's signature and enter the date signed
- Obtain the signature of legal guardian, DPOA-HC, or other legal representative, when applicable
  - This signature should match the name of the person authorizing the disclosure.

AUTHORIZATION TO DISCLOSE SUBSTANCE ABUSE TREATMENT

When the form is completed to request disclosure of **substance abuse treatment information**, the participant must also review, sign and date this section.

REVOCATION

This section shall be completed if the participant or the individual with legal authority to act as a representative for the participant wishes to revoke the authorization. The participant or representative must send the form to the department, facility, agency, or entity indicated at the beginning of the form.

- Enter the date of revocation
- Enter the participant's name
- Obtain signature of the participant or their legal representative, as appropriate

DISTRIBUTION

- One copy shall be provided to the participant/representative
- A copy shall be sent to the agency disclosing/releasing the information
- A copy shall be uploaded into the participant's electronic case record