AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION IN ACCORDANCE WITH 45 C.F.R. §164.508 (HIPAA) & THE DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT OF 1978

I hereby authorize _____ to send and/or release all documents that are found in my child's, _____(Date of Birth: _____) education file, housing file, public benefits file, social security file, employment file, medical file, mental health file, and social work file, including information about [my/my child's] medical diagnosis, condition, and treatment, including information about [my/my child's] mental health condition or treatment, [my/my child's] health insurance information, and information that identifies [me/my child], including [my/my child's] name, address, telephone number, and other demographic information, to **[organization/attorney name]**, its attorneys and agents (collectively, "**XYZ**"), and to discuss those documents and the information contained in them with **[organization/attorney name]**.

Commented [RG1]: Insert as appropriate

[Organization/Attorney Name] may receive, use, and share the information described above in order to provide legal services to [me/my child] and for **[organization/attorney name]** internal evaluation and research to improve legal service delivery.

[Organization/Attorney Name] may further disclose this information to those involved in [my/my child's] case, such as experts and other supporting professionals, including in court at trial, for the purpose of providing legal services to [me/my child].

I understand that once my health information is shared with **[organization/attorney name]**, federal privacy laws may no longer protect the information, which may be shared with other third parties by **[organization/attorney name]** pursuant to this authorization and may be subject to re-disclosure by those individuals.

I further understand that:

- I do not have to sign this authorization. My treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected.
- I am entitled to a copy of this signed authorization.
- This authorization will remain in effect until I revoke (cancel) it, at which point it will expire.
- I may revoke (cancel) this Authorization at any time by faxing a signed, written request to [INSERT POINT OF CONTACT], at which point _____ will immediately cease disclosing my health information to **[organization/attorney name]**. However, revoking this authorization will not affect **[organization/attorney name]**'s ability to use and disclose my/my child's health information that it has already received.
- This authorization will expire 365 days from the date of this authorization indicated below.
- This information has been disclosed to **[organization/attorney name]** from records whose confidentiality is protected by District of Columbia law. The unauthorized disclosure or re-disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosure or re-disclosure may be made pursuant to this valid authorization by me or as provided in Titles III and IV of the Act. The Act provides for civil damage and criminal penalties for violations.
- I have the right to inspect the record of [my/my child's] mental health information.

ACCEPTED AND AGREED:

By:

_____

Name:

_____

Relationship to Patient[1]:

_____

Date:

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, GENETIC TESTING, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED.

YES, DISCLOSE THIS INFORMATION

*_____

NO, **DO NOT** DISCLOSE THIS INFORMATION

*_____

[1] Guardian signature required if patient is under 18 years old.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION IN ACCORDANCE WITH 45 C.F.R. §164.508 (HIPAA) & THE DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT OF 1978

I hereby authorize _____ to send and/or release all documents that are found in my, _____(Date of Birth: _____) housing file, public benefits file, social security file, employment file, medical file, mental health file, and social work file, including information about my medical diagnosis, condition, and treatment, including information about my child's mental health condition or treatment, my child's health insurance information, and information that identifies me, including my name, address, telephone number, and other demographic information, to **[organization/attorney name]**, its attorneys and agents (collectively, "XYZ"), and to discuss those documents and the information contained in them with **[organization/attorney name]**.

Commented [RG1]: Insert as appropriate

CLC may receive, use, and share the information described above in order to provide legal services to me/my child and for CLC's internal evaluation and research to improve legal service delivery.

CLC may further disclose this information to those involved in my/my child's case, such as experts and other supporting professionals, including in court at trial, for the purpose of providing legal services to me/my child.

I understand that once my health information is shared with CLC, federal privacy laws may no longer protect the information, which may be shared with other third parties by CLC pursuant to this authorization and may be subject to re-disclosure by those individuals.

I further understand that:

- I do not have to sign this authorization. My treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected.
- I am entitled to a copy of this signed authorization.
- This authorization will remain in effect until I revoke (cancel) it, at which point it will expire.
- I may revoke (cancel) this Authorization at any time by faxing a signed, written request to [INSERT POINT OF CONTACT], at which point _____ will immediately cease disclosing my health information to **[organization/attorney name]**. However, revoking this authorization will not affect **[organization/attorney name]**'s ability to use and disclose my/my child's health information that it has already received.
- This authorization will expire 365 days from the date of this authorization indicated below.
- This information has been disclosed to **[organization/attorney name]** from records whose confidentiality is protected by District of Columbia law. The unauthorized disclosure or re-disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosure or re-disclosure may be made pursuant to this valid authorization by me or as provided in Titles III and IV of the Act. The Act provides for civil damage and criminal penalties for violations.

ACCEPTED AND AGREED:

By:

_____

Name:

_____

Relationship to Patient:

_____

Date:

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, GENETIC TESTING, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED.

YES, DISCLOSE THIS INFORMATION

*_____

NO, **DO NOT** DISCLOSE THIS INFORMATION

* _____

DEPARTMENT OF CONSUMER & REGULATORY AFFAIRS

Housing Inspection Records Release Form

Please complete the form below in its entirety.

Requestor First Name:_____ **Requestor Last Name:**_____

Relationship to Tenant/Owner: ☐ **Attorney** ☐ **Self** ☐ **Agent** **Bar #:**_____

Tenant First Name:_____ **Tenant Last Name:**_____

(Only complete the tenant name section if the name is different than requestor above.)

Property Address Including Unit Number (If applicable):_____

Name of Requestor's Agency/Firm (If applicable):_____

Phone Number:_____ **Mobile Number:**_____ **Email Address:**_____

Inspection(s) Date(s):_____

Document(s) Requested:

☐ Notices of Violation (NOV)

☐ Notices of Infraction (NOI)

☐ Inspection Report

☐ Inspection Photographs

☐ Inspection Activity Log

I,_____, authorize the Department of Consumer and Regulatory Affairs to release the above-referenced documents to _____ (Tenant/ Representative), collected during the course of the residential housing unit inspection as of the inspection date requested.

_____ _____

Tenant (Signature) **Date**

_____ _____

Requestor (Signature) **Date**