STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
Margaret M. O'Neill Bldg., Third Floor, Suite 1
410 Federal Street
Dover, Delaware 19901
302-739-3621

The Honorable John Carney
Governor

John McNeal
SCPD Director

Authorization to Use or Disclosure Protected Health Information – Documents to be Reviewed and Customized Prior to Use

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Delaware law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name:

_____

Other Name(s) Used: _____ Date of Birth: _____

Address:_____ City:_____ State:_____

Zip Code:_____ Phone: (_____)_____

Email: _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name:

_____

Address: _____City:_____ State:_____

Zip Code:_____ Phone: (_____)_____ Fax: (_____)_____

Information regarding entity who can receive and use this information to process request:

Name:

_____

Address: _____

City:_____ State:_____

Zip Code:_____ Phone: (_____)_____ Fax: (_____)_____

Specific information to be disclosed:
□ Medical Records from (insert date) _____ to (insert date) _____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other:

_____

_____

Include: (*Indicate by Initialing*)

_____ Medical Records relating to Traumatic Brain Injury diagnosis and treatment

_____ Mental Health Records (Except Psychotherapy Notes)

Reason for release of information:
(Choose all that Apply)
□ Eligibility Determination for State Fund Assistance
□ Disability Assessment
□ Treatment/ Medical Care
□ Billing or Claims
□ Other *(Specify)*:
_____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. However, determination of treatment, payment, enrollment or eligibility for receipt of benefits (as applicable) are conditioned upon my signing of this authorization form if I wish to request assistance.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the individual for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the state agency listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **TRAUMATIC BRAIN INJURY, MEDICAL RECORDS, DRUG, ALCOHOL**, **SUBSTANCE ABUSE,** and **MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative:
_____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____