GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Authorization to Disclose Medical or Dental Information

****Si usted no entiende el idioma Inglés, favor de pedir este formulario en Español**.**

Instructions

- Use this Authorization to authorize CFSA to disclose medical or dental information about a client (adult or child). Also, use this Authorization to disclose medical or dental information to CFSA.
- Do not use this Authorization for the release of mental health or substance abuse information. Instead, use the "Authorization to Release Mental Health and Substance Abuse Information".
- If the client or personal representative is Spanish-speaking and does not read English, give her or him the Spanish version of this Authorization.
- If a client is physically unable to complete the Authorization, CFSA staff may complete the Authorization under the direction of the client, or her or his personal representative, as long as the client, or her or his personal representative, signs or marks the Authorization.
- This Authorization must be signed by someone who legally can make decisions regarding the health care of the individual who is the subject of the health information. This is generally the individual if he or she is 18 years of age or older. For individuals under 18 years of age, this is generally the parent or legal guardian. However, a child under 18 years of age may author the release of information concerning the prevention, diagnosis or treatment of pregnancy or its lawful termination, or a sexually transmitted disease. **If the parent or legal guardian is not available to sign, or there are questions about who can sign, contact Health Services or the Office of General Counsel for directions on how to proceed.**
- Use a separate Authorization for each disclosure of information to CFSA or by CFSA.

Section A: Individual who is the subject of the information		
Last Name:	First Name:	Middle Initial:
Any other name used:		
Address: *(Street Address/City/ State/Zip)*		
Telephone:		
Date of Birth: (*Month/Day/Year)*	Social Security Number:	

Section B: Authorized use or disclosure

I, _____ , authorize _____

(individual or personal representative) *(person/organization authorized to disclose information)*

_____

to disclose the following information concerning the above-identified person to: _____

_____ .

(person/organization authorized to receive information)

Information Authorized to be Released *(Check all that apply and provide additional information as needed):*

Date of Service (specify dates or date range): _____ to _____

Release the following information (check (☑) all that apply):

All Records	Inpatient Records	Outpatient Records	Dental Records
Immunization Record	Emergency Room Records	Well-Child/Physicals	
Laboratory Records	Radiology Records	Discharge Summary Reports	

In authorizing this disclosure, I understand that this information will be used for the purpose of:

_____

_____

OR

This Authorization is made at my request and I elect not to state the purpose.

- I understand that the above-named individual's health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome, (AIDS) or human immunodeficiency virus (HIV) where applicable.
- I understand that this Authorization permits the release of both oral information and documents.
- I understand that the information used or disclosed on the basis of this Authorization could be disclosed again by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that I may revoke this Authorization at any time by giving my written revocation to:

D.C. Child and Family Services Agency
Attention: CFSA Privacy Office
200 I Street, SE
Washington, DC 20003

- I understand that revocation of this Authorization will *not* affect any action CFSA took in reliance of this Authorization before it received written notice of my revocation.
- I understand that this Authorization will expire 365 days from the date on which I sign it, and that I may sign a new Authorization for an additional expire 365 day period.
- I have received a copy of this Authorization.
- **I understand that this Authorization is voluntary and that CFSA will not condition any treatment that would otherwise be provided on this Authorization.**

Section C: Signature

Signature:	If this authorization is signed by a personal representative on behalf of the individual, complete the following:
Print Name (*Last/First/Middle Name*):	Personal Representative's Name:
Address:	Relationship to Individual *(check one):* Parent Legal guardian Legal Custodian
Phone number:	
Date:	

THIS AUTHORIZATION EXPIRES 365 DAYS FROM THE APPROVAL DATE.

Include this Authorization in the individual's records and provide a copy to the individual or their personal representative.