

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency



Authorization to Disclose Mental Health or Substance Abuse Information

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

Instructions

- Use this Authorization to authorize CFSA to disclose mental health or substance abuse information about a client (adult or child). Also, use this Authorization to disclose mental health information or substance abuse information to CFSA.
- Do not use this Authorization for the release of health information that is not mental health or substance abuse information. Instead, use the "Authorization to Disclose Medical or dental 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, except as provided below, generally the parent or legal guardian if the individual is under 18 years of age. For mental health information, if the individual is between 14 and 18 years of age, the child and the parent or legal guardian must sign the consent unless the child received the mental health treatment without the parent/legal guardian's consent; in that circumstance, if CFSA is seeking the disclosure of information concerning the services or supports received, the child alone is the person who must sign the Authorization. **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)		



D.C. Child and Family Services Agency ▪ 200 I Street SE, Washington, DC 20003 ▪ (202) 442-6100 ▪ www.cfsa.dc.gov
<http://dc.mandatedreporter.org> ▪ www.adoptdckids.org ▪ www.fosterdckids.org ▪ Facebook/CFSA DC ▪ Twitter@DCCFSA

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):

- | | | |
|--|---|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Inpatient Records | <input type="checkbox"/> Outpatient Records |
| <input type="checkbox"/> Discharge Summary Reports | <input type="checkbox"/> Laboratory Records | <input type="checkbox"/> Emergency Room Records |

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

- I understand that this Authorization permits the release of both oral information and documents.
- I understand that the client has the right to inspect her or his record of mental health information.
- 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 365 days. The Authorization will expire on _____.
- 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):
Phone number:	<input type="checkbox"/> Parent
Date:	<input type="checkbox"/> Legal guardian
	<input type="checkbox"/> Legal Custodian

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.



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