

**Washington Legal Clinic for the Homeless**

1200 U Street, NW, Third Floor, Washington, DC 20009  
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**REQUEST AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

\_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS: \_\_\_\_-\_\_\_\_-\_\_\_\_  
PATIENT'S PRINTED NAME

I hereby authorize use or disclosure of protected health information about me as described below. You are authorised to furnish both oral and written reports to the below named attorneys as requested by them on any of the forgoing matters.

- 1) I authorize the following person(s), and/or organization(s), such as my physician or health care provider, to disclose my protected health information:

NAME/ORGANIZATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

- 2) I authorize the following person(s) and/or organization(s) to request and receive my protected health information, as disclosed by the person(s) and/or organization(s) above:

NAME/ORGANIZATION: Washington Legal Clinic for the Homeless, attorneys and representatives

ADDRESS: 1200 U Street, NW, Third Floor, Washington, DC 20009

- 3) I authorize disclosure of all or any portion of the following:
  - a. Hospital records, x-rays, x-ray readings and reports, laboratory records and reports, tests of any type and character and reports thereof, statements of charges, and any and all of my records pertaining to hospitalization, history, condition, treatment, diagnosis, prognosis, etiology or expense;
  - b. Medical records, including my record cards, x-rays, x-ray readings and reports, tests of any type and character and reports thereof, statements of charges, and any and all of my records pertaining to hospitalizations, history, condition, treatment, diagnosis, prognosis, etiology, or expense;
  - c. Subsections (a) and (b) apply to all hospitals and medical records regardless of the nature of the treatment or tests administered including those records relating to alcohol and drug abuse and HIV/AIDS

And specifically: \_\_\_\_\_

- 4) PURPOSE: This Request and Authorization is for the purpose of asserting my legal rights and protecting the legal remedies available to me under federal and state law. This consent form is pursuant to the applicable state and federal statutes and regulations that provide that health records may only be furnished to third parties with the written authorization of the patient.
- 5) EXPIRATION OF AUTHORIZATION: This authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_, OR upon occurrence of the following event: closure of my case file at the Washington Legal Clinic for the Homeless.
- 6) RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time by notifying the health care provider identified above in writing. I understand that the revocation is only effective after it is received by the provider. I understand that any disclosure made prior to the revocation of this authorization will not be affected by the revocation.
- 7) TREATMENT OR OTHER BENEFITS NOT CONDITIONED ON FORM: I understand that the health care provider identified above may not condition treatment or other benefits on whether or not I sign this authorization form.
- 8) POTENTIAL FOR REDISCLOSURE: I understand that after the protected health information described above is disclosed pursuant to this authorization, it might be redisclosed and no longer protected by federal or other law.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

AUTHORITY OF PARENT OR GUARDIAN: \_\_\_\_\_ (If under 18 years of age)