Washington Legal Clinic for the Homeless
True Reformer Building, 1200 U Street, NW, Third Floor, Washington, DC 20009
(202) 328-5500 / (202) 328-5515 (FAX) / www.legalclinic.org

AUTHORIZATION TO DISCLOSE PROTECTED MENTAL HEALTH INFORMATION
DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT (D.C. Code § 7-1201 et seq.)

_____ D.O.B: _____/_____/_____ SS: _____-___-_____
PATIENT'S PRINTED NAME

I hereby authorize the disclosure of my protected health information as described below.

1) I authorize the following person(s) and/or organization(s), such as my physician or other mental health professional, 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 the following specific information:

   _____

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

   _____ both now and in the future, and that this authorization of disclosure is limited to information that is now in existence.

I understand that the Washington Legal Clinic for the Homeless is subject to the confidentiality requirements of the D.C. Mental Health Information Act and HIPAA. I further understand that this information cannot be re-disclosed to other parties without my authorization and that the law requires this notice:

> *The unauthorized disclosure of mental health information violates the provisions for the District of Columbia Mental Health Information Act of 1978 (§§ 7-1201.01 to 7-1207.02). Disclosures may only be made pursuant to a valid authorization by the client, or as provided in Titles III or IV of that act. The act provided for civil damages and criminal penalties for violations.*

I understand that I have the right to inspect my record(s) of mental health information. This authorization is subject to revocation in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

SIGNATURE: _____ **DATE:** _____/_____/_____

AUTHORIZATION EXPIRES ON: _____/_____/_____ (Not to exceed sixty (60) days from the date of authorization)

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

Copies must be: (1) Provided to patient, (2) Included in patient record, and (3) Accompany disclosures.
Note: This information is not to be used in connection with obtaining life or health insurance.