AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION IN ACCORDANCE WITH 45 C.F.R. §164.508 (HIPAA) & THE DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT OF 1978

I hereby authorize **RELEASING AGENCY** to send and/or release all documents that are found in my child's, **CHILD NAME** (Date of Birth: **DATE OF BIRTH**) education file, housing file, public benefits file, social security file, employment file, medical file, mental health file, and social work file, including information about [my/my child's] medical diagnosis, condition, and treatment, including information about [my/my child's] mental health condition or treatment, [my/my child's] health insurance information, and information that identifies [me/my child], including [my/my child's] name, address, telephone number, and other demographic information, to **[organization/attorney name]**, its attorneys and agents (collectively, "**XYZ**"), and to discuss those documents and the information contained in them with **[organization/attorney name]**.

[Organization/Attorney Name] may receive, use, and share the information described above in order to provide legal services to [me/my child] and for **[organization/attorney name]** internal evaluation and research to improve legal service delivery.

[Organization/Attorney Name] may further disclose this information to those involved in [my/my child's] case, such as experts and other supporting professionals, including in court at trial, for the purpose of providing legal services to [me/my child].

I understand that once my health information is shared with **[organization/attorney name]**, federal privacy laws may no longer protect the information, which may be shared with other third parties by **[organization/attorney name]** pursuant to this authorization and may be subject to re-disclosure by those individuals.

I further understand that:

- I do not have to sign this authorization. My treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected.
- I am entitled to a copy of this signed authorization.
- This authorization will remain in effect until I revoke (cancel) it, at which point it will expire.
- I may revoke (cancel) this Authorization at any time by faxing a signed, written request to [INSERT POINT OF CONTACT], at which point **RELEASING AGENCY** will immediately cease disclosing my health information to **[organization/attorney name]**. However, revoking this authorization will not affect **[organization/attorney name]**'s ability to use and disclose my/my child's health information that it has already received.
- This authorization will expire 365 days from the date of this authorization indicated below.
- This information has been disclosed to **[organization/attorney name]** from records whose confidentiality is protected by District of Columbia law. The unauthorized disclosure or re-disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosure or re-disclosure may be made pursuant to this valid authorization by me or as provided in Titles III and IV of the Act. The Act provides for civil damage and criminal penalties for violations.
- I have the right to inspect the record of [my/my child's] mental health information.

ACCEPTED AND AGREED:

By:

_____

Name:

_____

Relationship to Child:

_____

Date:

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, GENETIC TESTING, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED.

YES, DISCLOSE THIS INFORMATION

* _____

NO, **DO NOT** DISCLOSE THIS INFORMATION

* _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION IN ACCORDANCE WITH 45 C.F.R. §164.508 (HIPAA) & THE DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT OF 1978

I hereby authorize **RELEASING AGENCY** to send and/or release all documents that are found in my, **CLIENT NAME** (Date of Birth: **DATE OF BIRTH**) housing file, public benefits file, social security file, employment file, medical file, mental health file, and social work file, including information about my medical diagnosis, condition, and treatment, including information about my child's mental health condition or treatment, my child's health insurance information, and information that identifies me, including my name, address, telephone number, and other demographic information, to **[organization/attorney name]**, its attorneys and agents (collectively, "**XYZ**"), and to discuss those documents and the information contained in them with **[organization/attorney name]**.

CLC may receive, use, and share the information described above in order to provide legal services to me/my child and for CLC's internal evaluation and research to improve legal service delivery.

CLC may further disclose this information to those involved in my/my child's case, such as experts and other supporting professionals, including in court at trial, for the purpose of providing legal services to me/my child.

I understand that once my health information is shared with CLC, federal privacy laws may no longer protect the information, which may be shared with other third parties by CLC pursuant to this authorization and may be subject to re-disclosure by those individuals.

I further understand that:

- I do not have to sign this authorization. My treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected.
- I am entitled to a copy of this signed authorization.
- This authorization will remain in effect until I revoke (cancel) it, at which point it will expire.
- I may revoke (cancel) this Authorization at any time by faxing a signed, written request to [INSERT POINT OF CONTACT], at which point **RELEASING AGENCY** will immediately cease disclosing my health information to **[organization/attorney name]**. However, revoking this authorization will not affect **[organization/attorney name]**'s ability to use and disclose my/my child's health information that it has already received.
- This authorization will expire 365 days from the date of this authorization indicated below.
- This information has been disclosed to **[organization/attorney name]** from records whose confidentiality is protected by District of Columbia law. The unauthorized disclosure or re-disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosure or re-disclosure may be made pursuant to this valid authorization by me or as provided in Titles III and IV of the Act. The Act provides for civil damage and criminal penalties for violations.

ACCEPTED AND AGREED:

By:

_____

Name:

_____

Date:

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, GENETIC TESTING, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED.

YES, DISCLOSE THIS INFORMATION

* _____

NO, **DO NOT** DISCLOSE THIS INFORMATION

* _____

DEPARTMENT OF CONSUMER & REGULATORY AFFAIRS

Housing Inspection Records Release Form

Please complete the form below in its entirety.

Requestor First Name:_____ **Requestor Last Name:**_____

Relationship to Tenant/Owner: ☐ **Attorney** ☐ **Self** ☐ **Agent** **Bar #**:_____

Tenant First Name:_____ **Tenant Last Name**:_____

(Only complete the tenant name section if the name is different than requestor above.)

Property Address Including Unit Number (If applicable):_____

Name of Requestor's Agency/Firm (If applicable):_____

Phone Number:_____ **Mobile Number**:_____ **Email Address**:_____

Inspection(s) Date(s):_____

Document(s) Requested:

☐ Notices of Violation (NOV)

☐ Notices of Infraction (NOI)

☐ Inspection Report

☐ Inspection Photographs

☐ Inspection Activity Log

I,_____, authorize the Department of Consumer and Regulatory Affairs to release the above-referenced documents to _____ (Tenant/ Representative), collected during the course of the residential housing unit inspection as of the inspection date requested.

_____ _____

Tenant (Signature) **Date**

_____ _____

Requestor (Signature) **Date**

District of Columbia Housing Authority
1133 North Capitol Street, NE Washington, DC 20002-7599
202-535-1000

Adrianne Todman, Executive Director

Applicant/Tenant/Participant/Landlord Records Release Form

Please complete either **Section 1** ***OR*** **Section 2,** ***AND*** page 2 (Do not complete both sections)

Section 1 For Applicants/Tenants/Participants

_____ _____ _____
Applicant/Tenant/Participant *Last Name* *First Name* *Middle*

_____ _____ _____
Head of Household *Last Name* *First Name* *Middle*

Housing Program: ❒ Waitlist ❒ HCVP ❒ Public Housing, Property Name_____

Property Address: _____

_____

Mailing Address: _____

_____

Applicant/Tenant/Participant (Head of Household) Social Security Number: _____ - _____ - _____

Phone Number: _____ Email Address: _____

Delivery Preference: ❒ Fax #: _____ ❒ Email ❒ Pick-Up

Section 2 For Non-Tenants/Non-Participants/Landlords

Requestor: ❒ Landlord ❒ Counsel ❒ Other Authorized Person

_____ _____ _____
Requestor *Last Name* *First Name* *Middle*

Requestor's Agency or Firm (if applicable): _____

_____ _____ _____
Tenant/Participant *Last Name* *First Name* *Middle*

Housing Program: ❒ Waitlist ❒ HCVP ❒ Public Housing, Property Name_____

Property Address: _____

_____

Requestor's Mailing Address: _____

_____

Phone Number: _____ Email Address: _____

Delivery Preference: ❒ Fax #: _____ ❒ Email ❒ Pick-Up

Specific Record of Information Requested (Please include dates and list documents if requesting multiple documents to help speed up the processing of your request):

_____

_____

_____

_____

_____

_____

_____

_____

Purpose of request:

- ❒ Office of Fair Hearings Informal Hearing, Date of Hearing _____
- ❒ Documents needed for pending lawsuit:
  - Case Name: _____
  - Case Number: _____
  - Next Court Date: _____
- ❒ Other: _____

Applicant/Tenant/Participant/Landlord/Other Requestor MUST provide a valid photo identification when requesting records. Requests for records may be made by and released to the Applicant/ Tenant's/Participant's/ Landlord's counsel if the requestor provides an authorization form that was signed by the Applicant/Tenant/Participant/Landlord. The requestor will be contacted when the documents are available.

_____ _____

Signature of Requestor Date

Received by: _____ Date: _____ Dept: _____

****Pursuant to 14 DCMR §8903 & §6307, DCHA may charge twenty-five (25) cents per page for each page in excess of seventy-five (75).****