

HIPAA Authorization for Disclosure to Non-Covered Entities

Patient Details

Address

Name (First/Middle/Last)

City

Date of Birth (mm/dd/yyyy)

State

Phone

Zip

Information about this Consent

By submitting this form, you are authorizing CRISP DC to share your protected health information (PHI) with any/all community-based organizations (CBOs) registered with CRISP DC. Once you have registered this form, the organizations will have access to your protected health information (lab results, hospital paperwork, diagnosis, clinical notes, mental health, etc.) held within the HIE from participating organizations. By submitting this form, you are authorizing CRISP DC to share your protected health information (PHI) with any/all community-based organizations (CBOs) registered with CRISP DC.

Information to Be Disclosed and How

I understand and acknowledge that my PHI may contain health information that I may consider sensitive. I authorize the disclosure of my clinical data via the HIE Portal query. This could include but may not be limited to the following:

- Lab results
- Medication lists
- Hospital discharge summaries
- Mental health information
- Claims data

Release Information Via:

Clinical Data Only

Disclose my clinical data via the HIE Portal query only. This could include but may not be limited to my lab results, medication lists, hospital discharge summaries and mental health information.

From Whom

I authorize CRISP DC to release all my PHI from all my health care providers and payers who participate with CRISP DC. This could include information from providers, payers and other public health, care coordination and social service organizations.

To Whom

I authorize CRISP DC to release my information to any/all community-based (CBOs) registered with CRISP DC.

REVOKING MY PERMISSION

I understand that I may revoke this consent at any time, by requesting one of my CRISP DC participating providers to deactivate my consent in person or via written request. I understand that my information will be shared during the time the consent is active and my health care team may use this information for treatment, payment, and health care operations in accordance with state and federal law. I understand that the revocation will not affect any reliance, action, or disclosure of information by the organization that was authorized to release my information before it received notice of my revocation of my consent. I understand that CRISP DC cannot retrieve information once it is released; if I revoke my consent, whatever has been shared before that consent may continue to be in the files of the entities with whom it was shared before I revoked my consent and may be further shared in accordance with HIPAA and state law.

Required Statements

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) by requesting a CRISP DC participant to deactivate my consent in person or via written request. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization. After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law.

Signature/Attestation

I hereby attest that I have obtained a WRITTEN and SIGNED HIPAA Authorization as required by applicable law, including 45 CFR 164.508, to provide the patient's protected health information to the listed organization(s). I also attest that I will retain this HIPAA Authorization and make it available to CRISP DC upon request. If the HIPAA Authorization is revoked or expired, I will immediately inform CRISP DC. I have conveyed to the patient that CRISP DC cannot revoke information once it is released; if the patient revokes the authorization or it expires, whatever has been shared before that time may continue to be in the files of the entities with whom it was shared before the HIPAA Authorization was revoked, and those entities may continue to use and share it in accordance with applicable law.

Signature of Patient or Legal Guardian, Parent, or Legally Authorized Representative

Printed Name