Rhode Island Department of Human Services

AUTHORIZATION FOR DISCLOSURE OR USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my record. *(Name of Applicant/Patient)*

My Date of Birth: ____ / ____ / ____ My Security Number: _____ - _____ - _____

II. My information is to be disclosed by:

Any Medical Care Provider

_____
Name of Person/Organization

_____
Address

_____
City/ST/Zip

And is to be provided to:

Department of Human Services
Long Term Services and Supports
P.O Box 8709
Cranston, RI 02920

III. The purpose or need for this release of information is:

- ☒ I am applying for Medical Assistance
- ☐ I am applying for other DHS Services
- ☐ My own personal and private reasons
- ☐ Other (*specify*): _____

IV. The information to be disclosed: (*check only ONE of the following boxes*)

- ☐ Entire Health Record
- ☐ Health Insurance Information
- ☒ All of the information (except the boxes I checked) in Section VI below
- ☐ Other (*specify*): _____
- ☐ **Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)**

I would also like the following sensitive information disclosed: (*check the applicable box*(es))

- ☒ Alcohol/Drug Abuse Treatment/Referral
- ☒ HIV/AIDS-related Treatment
- ☒ Sexually Transmitted Diseases
- ☒ Mental Health (Other than Psychotherapy Notes)

V. I understand that if I am applying for enrollment, recertification, or other services, this release covers all my medical/health care providers, including the provider named above as well as any other person, facility, program or plan I have told you about on my written application(s) for Rhode Island Department of Human Services (DHS) programs, and on the necessary DHS forms, specifically the AP-70 forms and the MA-63 forms. I understand further that this authorization is required as a condition of obtaining eligibility and services and shall be used by DHS only for such purposes. Therefore, failure on my part to sign this authorization may affect my eligibility and/or the scope of services I may obtain. Additionally, I agree to the use of a fax or a photocopy of this form for the release or disclosure of the information.

I also understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES and that, if I do, DHS may condition my eligibility and access to services on my decision to revoke. In addition, any information disclosed to DHS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Heath Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below.

_____
(Enter if different from one year after the date below)

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Authorized Representative **Relationship to the patient** **Date**

VI. Specific Information I do NOT want disclosed: (*check the applicable box(es)*)

☐ Discharge Summary w/lab data	☐ Progress Notes	☐ Laboratory Data	☐ Psychiatric Exam
☐ History & Physical Examination	☐ Treatment Plan	☐ Psychological Test	☐ Social Service History
☐ Vocational	☐ Medical	☐ Educational	☐ Financial
☐ Minimum Data Set	☐ Nurses' Notes	☐ Care Plans	☐ Dental Records
☐ Photos/Videos/Digital Images	☐ Billing Statements	☐ Consultant Reports	☐ Dietary Records
☐ Emergency Care Records	☐ X-ray Reports	☐ Diagnostic Results	

Instructions for Completing Form DHS-25M

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.

2. Section I – print name of the patient whose information is to be released.

3. Section II – print the name and address of the person/organization authorized to release the information. Also, provide the name of the person, unit and address that will receive the information.

4. Section III – state the reason why the information is needed (e.g., disability claim, continuing medical care)

5. Section IV – check ONE of the listed boxes.

    a. Entire Record – the patient's complete medical record except for the sensitive information (e.g., alcohol/drug abuse treatment referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health/ other than psychotherapy notes)

    b. All of the information (except the boxes I checked) in Section VI below – the patient should check only those boxes the patient does NOT wish to have disclosed

    c. Other *(specify)* – specific information specified by the patient (e.g., CHS, billing, employee health)

    d. Psychotherapy Notes ONLY – in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.

    Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

    e. RELEASE OF SENSITIVE INFORMATION – check alcohol-drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases, mental health (other than psychotherapy notes) – patient must check the appropriate box!

6. Section V – sign and date. If a different *expiration* date is desired, specify a new date.

7. Section V – Authorized Representative (e.g., legal guardian, power of attorney)

8. Section IV – Specific information the patient does NOT want disclosed.

9. A copy of the completed Form DHS-25M will be given to the patient.