DISTRICT 19 COMMUNITY SERVICES BOARD

FAX TRANSMITTAL COVER SHEET

Date: 8/18/2020

Total Number of Pages including Fax Transmittal Cover Sheet and Disclosure of Protected Health Information Cover Letter, if disclosing protected health information: 4

To: Rebecca Herbig	From: Ursula Hilton, Medical Records Tech.
Organization/Address: diaAbility Law Center	Program/Address: District 19 CSB
Phone: 804-662-9441	20 W. Bank St., Suite 7
Fax Number: 804-662-7057	Petersburg, VA 23803
	Phone: 804-862-8002 Ext. 3177
	Fax Number: 804-863-1665

Subject: E. Key

Message or Instructions: Ms. Herbig, Please see the attached copy of the letter that was sent to your office on 7/14/20. If you have any questions, please give me a call at the above number. Thank you.

Ursula Hilton

Confidentiality Notice: The documents accompanying this transmission contain confidential health information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the destruction of these documents.

DISTRICT 19 COMMUNITY SERVICES BOARD
INVALID AUTHORIZATION COVER LETTER

July 14, 2020

disAbility Law Center of VA
1512 Willow Lawn Dr., Ste. 100
Richmond, VA 23230

District 19 Community Services Board received your request for records on **Emanuel Key.** We are unable to process this request for records, as the information required to comply with the request is incomplete. In order to process your request, the authorization form must contain the required elements as specified by the federal and state confidentiality regulations that govern our services. The following required elements are incomplete/missing from your request:

__X__ **A description of the information to be used or disclosed- Per your authorization, you are requesting records that may or may not include SUD information.** ***According to 42 C.F.R. Part 2, Subpart C 2.31: A written consent to a disclosure under the regulations must include: How much and what kind of information is to be disclosed, including and explicit description of the substance use disorder information that may be disclosed.*** **If the information requested involves HIV status, the authorization must specifically permit use/disclosure of this information.**

____ The purpose of the use or disclosure

__X__ **An indication whether the authorization extends to information placed in the individual's record after the authorization was given, but before it expires;**

____ The name of the person or class of persons authorized to make the requested disclosure;

____ The name of the organization to whom D19 CSB may make the disclosure.

____ The effective date of the authorization

____ An expiration date, event or condition;

____ A statement informing the individual of the right to revoke the authorization, exceptions to the revocation right, and how the individual may revoke the authorization;

__X__ **A statement informing the individual that treatment or payment are not conditional upon the individual's willingness to sign the authorization;**

____ A statement that there is a potential for the PHI disclosed pursuant to the authorization to be subject to redisclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule;

____ A statement indicating that a copy of the authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with the individual's original health records;

__X__ **A statement indicating that the individual signing the authorization understands that he/she is giving his/her permission to the health care entity named on the authorization for disclosure of confidential health records;**

__X__ **The signature of the individual or the individual's authorized representative, if applicable; and**

____ The date of the signature

For your convenience, I am enclosing our **Authorization to Disclose Confidential Information (HIPAA 004)** which contains all of the required elements and may be completed and returned to us for processing.

If you are requesting a response via fax from District 19 CSB, please note that our agency policy limits faxing to urgent or emergency care situations only.

Please forward all future requests for information to:

District 19 Community Services Board
Attn: Medical Records
20 W. Bank St., Suite 7
Petersburg, Virginia 23803

If you have questions or concerns, feel free to contact me at (804) 862-8002 ext. 3177.

Respectfully,

Ursula Hilton

Ursula Hilton
Medical Records Technician

Enclosure

District 19 Community Services Board
AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

Consumer's Full Name	Social Security Number	Date of Birth

I hereby authorize:

Name of Person or Organization Phone # Fax #

Street Address City State Zip

to use/disclose/exchange the following healthcare information and records: (Check all that apply)

☐ Intake/Referral ☐ Diagnosis ☐ Treatment Plan ☐ Evaluation/Assessment ☐ Psychological Evaluation –*redisclosure from outside provider* ☐Psychiatric Evaluation/ Information ☐ Physical Health ☐ Medications ☐ Progress Notes☐ Discharge Summary ☐ Summary of Services Received ☐ Social History☐ Transportation ☐ Financial ☐ Employment ☐ Title IV-E Eligibility ☐ Participation & Attendance

☐ Other: _____ . Infectious Diseases: AIDS, HIV, TB

☐ ALL Substance Use (SUD) Records

☐ Only these Substance Use (SUD) Records: (*specific items for disclosure MUST be listed*):

_____

To/With: _____

Name of Person or Organization Phone # Fax #

Street Address City State Zip

The purpose of use/disclosure/exchange of this information is at the request of the individual. *If no specific purpose is selected, the records that are requested, per the request of the individual signing this form, will be released for general use*: (Check all that apply) ☐ Assessment ☐ Treatment ☐ Discharge Planning ☐ Benefits/Service Eligibility ☐ Coordination of care ☐ Legal (*which may include giving testimony*) ☐MCO (*specify*)_____ ☐ Other: _____

Dates of Service for Information: Complete this section **ONLY** if a specific time period is needed or known. If not specified, 1 year of records will be disclosed: _____/_____/_____to _____/_____/_____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care or other entity or person/s for disclosure of confidential health records. I want all persons and organizations to accept a copy or faxed version of this form as a valid authorization to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need. I understand that:

- District 19 CSB cannot condition treatment or payment on my willingness to sign this authorization. I may refuse to sign this authorization.
- This authorization will become effective upon the date signed below unless noted otherwise.
- Only the information needed to satisfy the stated purpose of this disclosure will be shared. I understand this will include information added after the authorization origination date and up until the authorization expiration date.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records. *(Use "Revocation of Authorization to Disclose Confidential Information" (HIPAA 008)).*
- A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. I understand that my Substance use disorder records are protected under federal law, including Federal regulations governing the Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- District 19 CSB, its employees and Board, are hereby released from any legal responsibility or liability for disclosing information as I have authorized by completing this form, or for the use of information by the person or organization receiving it.
- Upon request, a copy of this form will be provided to me.

Unless revoked, this authorization will automatically expire 90 days after my discharge, unless indicated by checking *Other*.

☐ Other (specific date or event is *required*): _____

Consumer's signature Date

Parent/Guardian/Authorized Representative's signature, when required Date

Witness signature optional, unless consumer's signature is a "mark" Date