Sample: Authorization for Use or Disclosure of Health Information

(Also referred to as: Sample Next of Kin Consent)

As the personal representative[1] of the individual (decedent) identified below, I, _____ _____ [print name] authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider who has provided payment, treatment, or services to, or on behalf of, the decedent to:

a. Release all health information described in Part A(1) below in his/her/its possession to [insert name of organization housing the Overdose Fatality Review (OFR) team], including protected health information (PHI),[2] regarding the following individual:

   Name: _____

   Address: _____

   Date of Birth: _____

   Social Security Number: _____

b. Respond to any questions from or discuss decedent's health information with: _____ _____ [insert name of organization housing the OFR team].

   Reason for disclosure: The purpose of this authorization for release of health information is to allow [insert name of OFR team] to conduct a complete review of the situation, utilization of community resources, and factors that may have contributed to the fatality of the decedent.

Part A: General Health Information

1. Information to be disclosed (if information to be used or disclosed includes mental health, substance use disorder, or HIV-related information, please complete Part B of this form that relates to that information):

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Reviewed by:

LAPPA

1 "Personal representative" means that, under applicable state law, the person is an executor, administrator, or other person with authority to act on behalf of the decedent or the decedent's estate.
2 As that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) and regulations prescribed under HIPAA.

Sample: Authorization for Use or Disclosure of Health Information (continued)

Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

2. This information is to be disclosed to: _____ [insert name, address, and email of organization housing the OFR team].

3. I understand that

   a. This authorization may be revoked at any time. I understand that if I revoke this authorization, I must do so in writing, by sending a written revocation to [insert name of organization housing the OFR team]. I understand that the revocation will not apply to information that has already been released in response to this authorization.

   b. Unless otherwise revoked, this authorization will remain in force for two years from date of execution, at which time it shall expire.

   c. Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in C.F.R. § 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

   d. The information obtained through this release of information may be reviewed by and shared with [insert name of OFR team] members and may be discussed at one or more [insert name of OFR team] meetings.

   e. All members of the [insert name of OFR team] are bound by confidentiality and data-sharing agreements, and no identifiable patient information will be disclosed outside of the review. Any redisclosure of information discussed at a/an [insert name of OFR team] meeting may violate various confidentiality statutes subject to penalty of law.

4. I acknowledge receipt of a signed copy of this authorization. _____ (initial here)

Signature of Decedent's
Personal Representative: _____

Date: _____

Relationship to Decedent: _____

Sample: Authorization for Use or Disclosure of Health Information (continued)

Part B: Special Categories of Medical Information

1. **Substance use disorder information**

   If the medical records of the decedent include information about drugs, alcohol, and/or substance use disorder, I consent to the release of that information and authorize the provider to send that information to [insert name of organization housing the OFR team].

   ☐ Yes ☐ No

   Substance use disorder information will be disclosed from records protected by federal confidentiality rules (including 42 C.F.R. Part 2). The federal rules prohibit [insert name of organization housing the OFR team] from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. 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 patient treated for substance use disorder.

2. **Mental health information**

   If the medical records of the decedent include mental health information, I consent to the release of that information and authorize the provider to send that information to [insert name of organization housing the OFR team].

   ☐ Yes ☐ No

3. **HIV/AIDS information**

   If the medical records of the decedent include HIV/AIDS information, I consent to the release of that information and authorize the provider to send that information to [insert name of organization housing the OFR team].

   ☐ Yes ☐ No

4. **Additional disclosure provision(s):** [Insert any disclosure language required by state or local law.]

   Signature of Decedent's Personal Representative: _____

   Date: _____

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