Coastal Counseling Center, PC

1417 North Battlefield Boulevard, Suite 260
Chesapeake, Virginia 23320
757-436-0605 (Voice) 757-436-0023 (Fax)

Authorization for the Release of Information
Mental Health Treatment

(Pease fill out this form <u>completely</u>)

Patient Name:_____ **D.OB:**_____/_____/_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone: _____

Parent, Guardian or Personal Representative Name:_____

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1. Receiving Party ***(Please fill this section completely)***

I hereby authorize _____***(Therapist/Physician)*** to:

☐ **Disclose** ☐ **Exchange** ☐ **Obtain from**: _____***(Person/Organization)***

Address: _____

City: _____State:_____Zip:_____

Telephone: _____

Fax: _____

☐ **Complete Medical Record** ***(please specify dates of service)***_____

☐ **Partial Medical Record** ***(please specify dates of service)*** _____

2. Description of Health Information to be Disclosed:
(Check all that apply)

☐ Assessment
☐ Diagnosis
☐ Psychosocial Evaluation
☐ Psychological Evaluation
☐ Psychiatric Evaluation
☐ Treatment Plan or Summary
☐ Current Treatment Update
☐ Medication Management Information
☐ Presence/Participation in Treatment
☐ Nursing/Medical Information
☐ Educational Information
☐ Discharge/Transfer Summary
☐ Continuing Care Plan
☐ Progress in Treatment
☐ Demographic Information
☐ Toxicology Reports/Drug Screens
☐ Other_____

3. Purpose of Disclosure

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If the purpose is the other than specified above, please specify:
☐ At my request
☐ Other: _____

4. Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Coastal Counseling Center. I further understand that a revocation of the authorization will not apply to any health information that has already been released in response to this authorization.

5. Expiration

Unless sooner revoked, this authorization expires on the following date_____/____/____or otherwise indicated_____

6. Conditions

I further understand that Coastal Counseling Center will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequence(s): **Delay or failure to process your request for medical records.**

7. Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally in paper format or electronically.

8. Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of **substance abuse treatment information** unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by C.F.R. Part 2.

I can ask to be given a copy of this authorization for my records.

_____ _____

Signature of Patient ***(or Patient's Representative)*** **Date**

_____ _____

Printed Name **Description of Authority to Act for Patient**

☐ Check here if Patient/Patient's Representative refuses to sign authorization

_____ _____

Signature of Staff Witness **Date**