Daleville Family Counseling, Inc.

AUTHORIZATION TO RELEASE INFORMATION

THIS INFORMATION WILL BE USED FOR EVALUATION AND/OR TREATMENT

Patient _____SS# _____DOB _____

☐ I hereby authorize _____ to RELEASE my PHI to:

_____

☐ I hereby authorize_____ to OBTAIN my PHI from:

_____

_____

Person or Agency Name Information is Going To

_____

Address (including city, state and zip code) Information is Going To

_____

Telephone Number Fax Number

INFORMATION TO BE RELEASED: (please check all that apply)

____ Bio psychosocial Assessment
____ Progress Notes
____ Psychosocial Assessment
____ Medical History & Physical
____ Medication Records
____ Discharge Summary
____ Treatment Plan
____ Psychiatric evaluation

The date range for this release is _____ to _____, and will expire on

_____.

I understand that without this release, my records are otherwise protected under the Federal and State Confidentiality Regulations, including the regulations set forth by the Healthcare Information Portability and Accountability Act (HIPPA) and cannot be disclosed except in accordance to those regulations. I understand and agree that even if I revoke this release, the laws of the Commonwealth of Virginia require disclosure of privileged information in situations of suspected child abuse, of suspected potential harm to oneself or another, and in instances where the court shall order the disclosure of privileged information or shall subpoena records. No information sent or received through this authorization may be released to any other persons or agency. I agree that a photocopy of this form and my signature below is as valid as the original.

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian of this child.

Patient/Guardian Signature _____ Date _____