The Center for Emotional Care

400 East Burwell Street, Salem, VA 24153
Phone: 540-387-3105 Fax: 540-387-3653

Authorization to Use or Disclose My Health Information

Patient Name: _____ DOB: _____

Patient Address: _____
(Street) (City) (State) (Zip)

Information is to be □ exchanged with or □ released from Providers of The Center for Emotional Care and:

Name/Agency: _____
Street Address: _____
City, State, Zip: _____
Phone/Fax Numbers: _____

Purpose of Release: □ Diagnosis/Treatment □ Communication □ Legal Representation □ Continuity of Care
□ Other: _____

Reason(s) for this authorization (check all that apply):
□ At my request
□ Other (specify):
_____ _____

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

□ Psychiatric Records □ Alcohol Abuse Treatment Information □ Verbal Treatment Information
□ Psychotherapy Notes □ Drug Abuse Treatment Information □ HIV/AIDS Information
□ Lab Results □ Psychiatric Test Results □ Consultations
□ Any and all health information maintained by The Center for Emotional Care
□ Other: _____

The recipient is authorized to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person to disclose or obtain protected health information. I further acknowledge that:

· I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
· The original or a copy of this authorization shall be included with my original records.
· I have the right to revoke this authorization at any time, except to the extent that action has been taken on it, by delivering the revocation in writing to the provider who is in possession of my health care 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. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR Part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR 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 alcohol or drug abuse patient.

If not previously revoked, this authorization will expire in: □ One year; □ On (specify date): _____

_____ _____ _____
Signature of Adult Patient or Legally Authorized Representative Relationship Date Signed

_____ _____
Signature of Minor Patient (if 14 or older) Date Signed