Counseling and Forensic Services, Inc.

1308 Devils Reach Rd.
Ste. 300
Woodbridge, VA 22192
(703) 492-2994

4900 Leesburg Pike
Ste. 300
Alexandria, VA 22302
(703) 379-0668

28 Ashby St.
Ste. 106
Warrenton, VA 20188
(703) 492-2994

Fort Evans Plaza
21-B Ft. Evans Road, N.E.
Leesburg, VA 20176
(703) 443-6917

Authorization to Release Confidential Health Records

Name: _____ **Date of Birth:** _____

I hereby authorize _____ to release/use/disclose/or obtain the following information: *(Check all that applies)*

- ☐ Discharge Summery
- ☐ Treatment Plans
- ☐ Substance Abuse Information
- ☐ Verbal Communications
- ☐ Progress Notes
- ☐ Polygraph Results
- ☐ Medical Information
- ☐ School Information
- ☐ Psychological Evaluation
- ☐ Risk Assessments
- ☐ Legal Information
- ☐ Work Information

Other: _____

To: _____ (____) _____ (____) _____
Name and title of organization/practioner *Phone #* *Fax #*

_____
Street Address *City* *State* *Zip Code*

Purpose of release/use/disclosure of information:
☐ Diagnosis/Treatment ☐ Discharge Planning ☐ Client's Request ☐ Other: _____

Special Circumstances/Restrictions: ☐ None ☐ Other: _____

As the person signing the authorization, I acknowledge that I am giving permission to the above named individual or company to disclose and use protected health care information. I have been informed that:

- I may refuse to sign this authorization.
- Refusing to sign this authorization does not affect my payment or participation in treatment.
- The original of this authorization shall be included in my file at Counseling and Forensic Services, Inc. as well as a notation concerning the persons or agencies to which disclosure was made.
- I have the right to revoke this authorization at any time. I understand that the revocation is not effective until delivered in writing to Counseling and Forensic Services, Inc.
- 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 HIPPA 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 disclosures of this information unless further disclosure is expressly permitted by your written authorization or as otherwise 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.

Unless revoked this authorization will expire: ☐ One year from date signed ☐ other *(specify date or event):* _____
This authorization may be disclosed effective: ☐ Immediately ☐ _____

This authorization ☐ ***does*** ☐ ***does not*** extend to information placed in my record after the date I sign this form.

_____ _____
Signature Date