Shenandoah Valley Counseling Center, LLC

Maggie Campbell, LCSW
Therapist

617 W. Main St. Waynesboro, VA
(540) 256-1320

mcampbell@svcc.us.com

Website: svcc.us.com

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# AUTHORIZATION TO RELEASE and /or EXCHANGE INFORMATION

I authorize _____ to discuss or release information and/or provide records to above therapist at Shenandoah Valley Counseling Center, LLC. Requested information may be sent through ___Fax; ___Email; ___Mail to the address specified above.

| **Agency/ Medical / Mental Health Provider**: (name and address) | **Client**:<br><br>**DOB:** |
|---|---|

☐ Information obtained only by discussion via phone conversation

**RECORDS AUTHORIZED TO BE RELEASED:**

- ☐ Admission history and physical
- ☐ Discharge summary
- ☐ Complete hospital chart
- ☐ Office notes
- ☐ Outpatient records
- ☐ Psychiatric and other mental health records
- ☐ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
- ☐ Medication(s)
- ☐ Other (specify):
- ☐ Lab reports
- ☐ Radiological images
- ☐ Consultation notes or reports
- ☐ Complaints or grievances filed, with responses or dispositions

**This information will be used for the purpose of :**

- ☐ Initiating / Continuing therapeutic process
- ☐ Providing advocacy services
- ☐ Other activities at the request of the individual
- ☐ Verifying my eligibility for services offered by the medical/behavioral insurance
- ☐ Maintaining / Improving Therapeutic Continuity

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that above name may re-disclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____
Patient or Representative Date

_____
Name of Representative (print)

_____
Relationship to Patient

**This authorization will expire one year from the date of the signature below.** I understand that I can revoke this authorization at any time by writing to the health care provider or to the above name agency, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

# Instructions for Authorization to Release Medical Information

## Instructions

- You can fill this form in on the computer for printing.
- When filling in the form on the computer, you can move between fields by using the TAB key, the ARROW KEYS, or the mouse. The SPACE BAR or a MOUSE CLICK will check or uncheck boxes.
- If you fill in too much text in a blank, the text block may be extended and the signature block may be forced onto a second page. This is okay, and this is also why the second page of this document is blank.
- You can print the form for signing after filling in the blanks. You do not need to save a copy to your computer.
- To simplify completing a copy of the form for many different providers, you may save a partially completed copy of the form on you computer and change only the provider or other information necessary for each additional copy before printing.

## Explanation of HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires an Authorization to Release Medical Information in order for health care providers to release medical information or records. New requirements for authorizations became effective April 16, 2003. This requirement also extends to organizations related to health care providers, such as insurance companies and other organizations closely associated with health care providers, and their contractors. It is necessary to use this form when requesting information from health care providers because this law requires specific information to be provided on an authorization. This form should not be used to request records not covered by HIPAA (records obtained from a source other than a health care provider).

Medical providers are mandated to protect information and to require the use of forms that comply with the law. This form complies with the requirements of HIPAA and should be accepted by all medical providers. However, if a medical provider insists that the provider's form be used, you may want to use that form if it will expedite the process of obtaining records. Please notify the AWPPW if this situation arises so that the problem can be resolved.