Assessment & Counseling of Williamsburg
1309 Jamestown Rd Ste 201
Williamsburg, VA 23185
Phone: 757-941-8182. Fax: 757-500-0134

AUTHORIZATION FOR RELEASING and/or REQUESTING INFORMATION

Client's Full Legal Name | **Social Security #** | **Date of Birth**

Authorize: Assessment & Counseling of Williamsburg **to** ☒ **disclose to *and/or* to** ☒ **receive from:**

Name of Individual and/or Organization to Whom Disclosure is to be made

Street Address | **City** | **State** | **Zip**

- **The following information for the treatment period of:** One Year

☒ **Discharge Summary**
☒ **Intake Summary/Mental Status Assessment**
☒ **Lab results**
☒ **Psychiatric consults/notes**
☒ **Medication(s) prescribed**
☒ **Diagnoses**
☒ **Progress notes**
☒ **Treatment plans**
☒ **Psychological and/or Psychiatric testing**
☒ **Medical History & Emergency Medical Information**
☒ **Substance Abuse information**
☒ **Social history & behavioral observations**
☒ **Verbal/Written information regarding progress in treatment**
☒ **All confidential school information (education eval. reports & IEP)**
☒ **Audio-video recordings, photographs, digital or other images (*specify*):**
☐ **Other (*specify):***

- **The Purpose for the disclosure of this information:**

☐ **Follow-up medical care** ☒ **Treatment planning/Coordination of Services** ☒ **My personal record/Use**
☐ **Other:**

As the person signing this consent, I understand that I am giving my permission to the above-named provider to disclose my confidential health care records that may include medical, psychiatric, HIV/AIDS and substance abuse information. I also understand that I have the right to revoke this consent at any time, except to the extent that action has been taken in reliance on it, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. A copy of this authorization concerning the person or agency to whom disclosure was made shall be included with my original health records.

If not previously revoked this authorization will terminate One (1) year from the date of signature or until no longer reasonably necessary to accomplish the purpose for which it is given or specific date or event:

If there are *No* changes to the above information, this consent may be extended from the original date by re-signing the second line below.

Signature of Client	Date Signed	Signature of Parent/Legally Authorized Representative/Guardian	Witness
1.			
2.			

NOTICE TO THE RECIPENT OF THIS INFORMATION - REDISCLOSURE PROHIBITION: This information has been disclosed to you from records whose confidentiality may be protected by Federal Law. Federal regulation (42 CFR Part 2) prohibits the receiving agency from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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 investigate or to prosecute any alcohol or drug abuse patient. If you give written consent to re-disclose your information by the recipient, it may no longer be protected by federal and state laws.

***Photocopies and Faxes of this form may be accepted in lieu of the original**