

COASTAL VIRGINIA COUNSELING

HELPING YOU REACH YOUR BEST

SUITE 308

101 N. LYNNHAVEN RD.

VIRGINIA BEACH, VIRGINIA 23452

TELEPHONE (757) 222-4944

FACSIMILE (757) 544-9880

AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MEDICAL INFORMATION

I, _____ hereby authorize _____ to:

Release medical psychiatric, alcohol and/or drug abuse, HIV testing, ARC, and/or AIDs information to:

Exchange information on an ongoing basis with:

Coastal Virginia Counseling, LLC

101 N. Lynnhaven Rd., Ste. 308

Virginia Beach, Virginia 23452

(757) 222-4944

(757) 544-9880 facsimile

for the purpose of personal, group and family therapy. The specific records/reports to be disclosed shall include:

<input checked="" type="checkbox"/> Complete Record	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab
<input type="checkbox"/> Abstract	<input type="checkbox"/> Consultations	<input type="checkbox"/> X-ray Reports/films
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Emergency	<input type="checkbox"/> Diagnostics
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Procedures/Operative	<input type="checkbox"/> Therapy Records
<input type="checkbox"/> Reports	<input type="checkbox"/> Patient Questionnaire	
<input type="checkbox"/> Other, Specify type: _____		
<input type="checkbox"/> Itemized Statement of account	For Date(s) of Stay/Treatment: <u>ALL</u>	

I understand that this consent is revocable upon written notice to the hospital/healthcare provider, except to the extent that action has already been taken on this authorization. Letters of revocations should be sent to the Medical Records Department. The authorization shall expire two years from the date stated below OR upon occurrence of the following event that related to me or to the purpose of the intended use or disclosure of information about me: my written revocation. Any information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Alcohol, drug, HIV, ACR and/or AIDS information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. Copies or faxes of this authorization are accepted only if agreed upon by both parties. It is expressly understood and agreed that any and all copies of this Authorization shall be valid and of the same force and effect as the original. I understand that the information disclosed pursuant to this authorization is subject to re-disclosure by The Dickerson & Smith Law Group, and no longer protected by state or federal confidentiality rules, regulations or law.

Client/Patient Signature

Date

Date of Birth

Social Security Number

Parent/Legal Guardian
