

Name:	MRN:	

Authorization for Releasing and/or Requesting Information

1657 Merrimac Trail, Williamsburg, VA 23185 • (757) 220-3200 • Fax (757) 229-7173

3804 George Washington Memorial Hwy, Yorktown, VA 23692

• (757) 898-7926 • Fax (757) 898-4505

921 Capitol Landing Road, Williamsburg, VA 23185 ● (757) 253-4074 ● Fax (757) 253-4018

GWCAC • 921 Capitol Landing Road, Williamsburg, VA 23185

• (757) 253-4047 • Fax (757) 253-4197

l,		
Individual's Full Legal Name	Last 4 SSN	Date of Birth
authorize Colonial Behavioral Health to \square disclose to	and/or to \square 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:		

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of my records.

Name:	MRN:
	-

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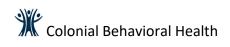
☐ Discharge Summary	Medical History & EmergencyMedical Information		
☐ Intake Summary/Mental Status Assessment	☐ Social History & Behavioral Observations		
☐ Lab Results	☐ Verbal/Written Information		
☐ Psychiatric Consults/Notes	Regarding Progress in Treatment		
☐ Medication(s) Prescribed	 All Confidential School Information Regarding Progress in Treatment 		
Diagnoses	☐ Audio-video Recordings,		
☐ Progress Notes	Photographs, Digital or Other Images (specify):		
☐ Treatment Plans			
☐ Substance Use Information	☐ Billing/Reimbursement Information		
☐ Psychological and/or Psychiatric Testing	Other (specify):		
The purpose for the disclosure of this information	n:		
☐ Follow up Medical Care	☐ My Personal Record/Use		
☐ Treatment Planning/Coordination of Services	Other (specify):		
As the person signing this consent, I understand t	that I am giving my permission to the above-		
named provider to disclose my confidential hea	alth care records that may include medical,		
psychiatric, HIV/AIDS and substance use informati	ion. I also understand that I have the right to		

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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

The printed date and time is in the footer of this document.



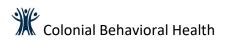
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I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. A copy of this authorization concerning the person or agency to which disclosure was made shall be included with my original health records.

If not previously revoked this authorization	on will terminate one (1)	year from the date of
signature or until no longer reasonably no	ecessary to accomplish th	e purpose for which it is
given or specific date or event:		
Comments:		
Signature of Individual	Date	Time
Signature of Parent/Guardian/AR	Date	Time
Signature of Witness	Date	Time

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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 use 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.

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