Colonial Behavioral Health

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

I, _____ _____ _____

Individual's Full Legal Name | Last 4 SSN | Date of Birth

authorize Colonial Behavioral Health 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: _____

Confidential

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- ☐ Discharge Summary
- ☐ Intake Summary/Mental Status Assessment
- ☐ Lab Results
- ☐ Psychiatric Consults/Notes
- ☐ Medication(s) Prescribed
- ☐ Diagnoses
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Substance Use Information
- ☐ Psychological and/or Psychiatric Testing
- ☐ Medical History & Emergency Medical Information
- ☐ Social History & Behavioral Observations
- ☐ Verbal/Written Information Regarding Progress in Treatment
- ☐ All Confidential School Information Regarding Progress in Treatment
- ☐ Audio-video Recordings, Photographs, Digital or Other Images (specify): _____
- ☐ Billing/Reimbursement Information
- ☐ Other (specify): _____

The purpose for the disclosure of this information:

- ☐ Follow up Medical Care
- ☐ Treatment Planning/Coordination of Services
- ☐ My Personal Record/Use
- ☐ Other (specify): _____

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 use 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.

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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 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: _____

Comments:

_____ _____ _____

Signature of Individual Date Time

_____ _____ _____

Signature of Parent/Guardian/AR Date Time

_____ _____ _____

Signature of Witness Date Time

Name: MRN:

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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.