Powhatan Family Counseling and Education Center
2156 Plainview Center
Powhatan, VA 23139
Phone: 804-598-9577 * Fax: 804-598-0084

AUTHORIZATION TO RELEASE INFORMATION

Name: _____ Date of Birth: ____/____/____ SSN: _____-____-_____

I authorize the clinical and/or administrative staff of:

Dr. Judith Cain-Oliver, LCP
Powhatan Family Counseling and Education Center
2156 Plainview Business Center
Powhatan, VA 23139
Phone: (804) 598-9577
Fax: (804) 598-0084

☐ **To release or** ☐ **To exchange information to/ with:**

_____
(Name of institution or individual to receive or disclose information)

_____
(Address of institution or individual to receive or disclose information)

_____
(Phone number and fax number of institution or individual to receive or disclose information)

The specific information to be released is as follows:

☐ Psychological Records ☐ Psychiatric Records ☐ Psycho/Social History ☐ Assessment ☐ Treatment Plan/ISP/IFSP/CSP
☐ Referral//Transition Information ☐ Discharge Summary ☐ Medical Records, including ☐ Office Notes and/or ☐ Lab results
☐ Birth Records ☐ Educational Records ☐ Vocational Records ☐ Criminal Justice Records ☐ Financial Information
☐ Other _____

HIV-related information and drug and alcohol information contained in the parts of the record indicated above will be released through this consent unless otherwise indicated. ___ Do Not Release

I want information to be exchanged *(check all that apply):*

☐ Written information (fax or mail) ☐ Verbally (via phone or face-to-face contact)

This authorization shall be in force and effect until date specified or one year from today at which time this authorization to use or disclose this personal health information expires. ___/___/___

I understand that I have the right to revoke this authorization at any time by informing Powhatan Family Counseling and Education Center in writing. This will stop Powhatan Family Counseling and Education Center from any further sharing of any of the information listed on this form except to the extent action has been taken in reliance herein. Withdrawal of consent will be effective upon receipt of written request.

_____ _____
Signature of patient or parent/guardian **Date**

I do ___ do not ___ want a copy of this release.

To the recipient of information: This information is being disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it 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.