Release of Information

** indicates a required field*

*** Client's name:**

*** Date of Birth:**

*** Phone:**

*** Address:**

The above listed patient authorizes:
First Colonial Psychotherapy Services
921 First Colonial Road, Suite 1711
Virginia Beach, VA 23454
Phone/Fax: (757)428-7500

*** To disclose my health information to: Physician/Person/Facility/Entity (Please include) Name/Phone/ Fax/ Address:**

*** To release the following information:**

- [ ] Diagnosis and Treatment Plan
- [ ] Progress Notes
- [ ] Questionnaires
- [ ] Drug/Alcohol Abuse Treatment Notes
- [ ] Mental Status Exam
- [ ] Billing Information/Invoices

*** State the Purpose of the Disclosure:**

- [ ] at my request (client)
- [ ] continuity of care
- [ ] employment reasons
- [ ] disability/life insurance
- [ ] transfer care
- [ ] other (specify)

If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information. _____

I consent to sharing information provided here.

I understand I have the right to inspect and obtain a copy of the records to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. I understand this authorization is voluntary. I understand the person(s) or organization(s) authorized to request and/or disclose this information may not condition the provision of treatment on the provision of an authorization. I understand I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the office authorized to make the release. I understand the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire on the following date (insert below) If I do not specify an expiration date, this authorization will expire 1 year form the signature. I understand that a Medical Records coping fee of $25 will apply for the release of my medical records.

* **Patient/Guardian Signature:** _____

I consent to sharing information provided here.

*** Parent/Guardian Representative: Print Name and Relationship**