Authorization for Disclosing and/or Requesting Health Information

Client Name: ______________________ **Case #:** ______________

Henrico Area Mental Health and Developmental Services is hereby authorized to:

☐ **DISCLOSE/SEND TO THE FOLLOWING PERSON/AGENCY:** ______________________

PRINT NAME OF PERSON OR AGENCY

PERSON/AGENCY'S PHONE # | STREET ADDRESS | CITY | STATE | ZIP

☐ Evaluation/Assessment	☐ Psychological Evaluation	☐ Medication(s) Prescribed	☐ Infectious Disease: AIDS, HIV, TB	☐ Specify other:
☐ Treatment	☐ Substance Abuse Information	☐ General Health Physical	☐ Case closing Summary	

THIS AUTHORIZATION IS EFFECTIVE BEGINNING:	Today's Date:		Other Date:	
AND WILL TERMINATE IN (NOT TO EXCEED 1 YEAR):				
☐ 90 Days,	☐ 365 Days (one year),	☐ At Discharge	☐ Upon the following date, event or condition:	

☐ **REQUEST/RECEIVE FROM THE FOLLOWING PERSON/AGENCY:** ______________________

PRINT NAME OF PERSON OR AGENCY

PERSON/AGENCY'S PHONE # | STREET ADDRESS | CITY | STATE | ZIP

☐ Evaluation/Assessment	☐ Psychological Evaluation	☐ Medication(s) Prescribed	☐ Infectious Disease: AIDS, HIV, TB	☐ Specify other:
☐ Treatment	☐ Substance Abuse Information	☐ General Health Physical	☐ Case closing Summary	

THIS AUTHORIZATION IS EFFECTIVE BEGINNING:	Today's Date:		Other Date:	
AND WILL TERMINATE IN (NOT TO EXCEED 1 YEAR):				
☐ 90 Days,	☐ 365 Days (one year),	☐ At Discharge	☐ Upon the following date, event or condition:	

METHODS PERMITTED TO DISCLOSE OR REQUEST HEALTH INFORMATION: ☐ written ☐ oral ☐ fax

PURPOSE FOR WHICH THIS INFORMATION IS TO BE USED OR DISCLOSED IS:
☐ Assessment ☐ On-going Treatment ☐ Follow - up Care ☐ Other: (Specify)

As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations or eligibility are not conditional upon giving authorization. The original or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. This authorization is automatically revoked upon termination of service.

The person who receives the records to which this authorization pertains may not redisclose them to anyone else without my separate written authorization unless such recipient is a provider who makes a disclosure permitted by law. A general authorization for the release of medical or other information is NOT sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or Federal law protect the disclosed confidential information. Federal Regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

______________________ ____________ ____________
Client Signature Date Signed Date of Birth

______________________ ____________
Client's Parent or Authorized Representative Signature Date Signed

SEND TO THE ATTENTION OF: ______________, **Henrico Area Mental Health and Developmental Services**

☐ Cypress Enterprises 101-A Roxbury Industrial Center Charles City, Virginia 23030 TEL: (804) 966-5753 FAX: (804) 966-5581	☐ East 4825 South Laburnum Ave Richmond, Virginia 23231 TEL: (804) 222-2607 FAX: (804) 236-9118	☐ Henrico Co. Regional Jail - East 17320 New Kent Highway Barhamsville, Virginia 23011-2354 TEL: (804) 652-1250, 1255 FAX: (804) 652-1254	☐ Lakeside House 5623 Lakeside Avenue Richmond, Virginia 23231 TEL: (804) 264-1007 FAX: (804) 264-0984	☐ Woodman-Central 10299 Woodman Road Glen Allen, Virginia 23060 TEL: (804) 727-8500 FAX: (804) 727-8480	☐ Woodman-ID 10299 Woodman Road Glen Allen, Virginia 23060 TEL: (804) 727-8511 FAX: (804) 727-8469
☐ Closed records 10299 Woodman Road Glen Allen, Virginia 23060 TEL: (804) 727-8539 FAX: (804) 727-8355	☐ East PACT 4825 South Laburnum Ave Richmond, Virginia 23231 TEL: (804) 236-8752 FAX: (804) 236-8759	☐ Henrico Co. Jail - West Box 27032 Richmond, Virginia 23273 TEL: (804) 501-4580, 4586, 4590 FAX: (804) 501-5804	☐ Providence Forge P. O. Box 461 Providence Forge, Virginia 23140 TEL: (804) 966-5959 FAX: (804) 966-5694	☐ Woodman-CM&A and MH SS 10299 Woodman Road Glen Allen, Virginia 23060 TEL: (804) 727-8600 FAX: (804) 727-8364	☐ Woodman-PIP 10299 Woodman Road Glen Allen, Virginia 23060 TEL: (804) 727-8372 FAX: (804) 727-8666
	☐ Hermitage Enterprises 8247 Hermitage Road Richmond, Virginia 23228 TEL: (804) 262-6665 FAX: (804) 262-2914	☐ Juvenile Detention Home P.O. Box 27032 Richmond, Virginia 23273-7032 TEL: (804) 501-5748 FAX: (804) 501-5438	☐ Radford 4915 Radford Avenue Richmond, Virginia 23230 TEL: (804) 359-3370 FAX: (804) 359-1649	☐ Woodman-PACT 10299 Woodman Road Glen Allen, Virginia 23060 TEL: (804) 727-8470 FAX: (804) 727-8364	

Keep a copy of authorization in chart