DISCOVERY COUNSELING & CONSULTING

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

I,_____, hereby authorize _____
(Client name) (DCC Clinician name)
To release/request my medical/behavioral health/educational records (including drug and alcohol related information) to/from:

_____ _____ _____
(Person/Agency/Provider) (Address) (Phone #)

_____ _____
Relationship to Client (Fax #)

Information to be disclosed/requested:
___ Intake/Assessment
___ Progress notes
___ Other (please specify)_____
This authorization expires on: _____
Information may be released/requested via: ___ phone ___ fax ___email ___ mail

As the person signing this authorization, I understand that I am giving my permission to the above named individual/agency for the disclosure of confidential health care records. I also understand that I have the right to revoke this consent at any time.
The person/agency who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless the recipient is a provider who makes disclosure as permitted by law.
I understand that I have the right to access my medical records in accordance with the law. I understand that Virginia law allows DCC to charge me a fee of $10.00 for search and handling, postage and shipping costs, and $0.50 per page for the first 50 pages and $0.25 per page thereafter. Insurance does not cover this cost.
I understand DCC has the right to deny me access to my records in certain circumstances in accordance with the law. If DCC denied me access to my medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health professional.
Please note that information disclosed to pursuant to this request is no longer under the control of DCC and may no longer be protected by federal or state law.

_____ _____
(Client signature) (Date)

_____
(Parent/guardian signature) (Date)

Client Date of Birth:_____ Last 4 digits of client social security number:_____

Discovery Counseling & Consulting
7760 Shrader Rd
Suite B
Henrico, VA 23228
(804) 591-0002
(804) 501-0101- fax