DISCOVERY COUNSELING & CONSULTING

7760 Shrader Rd. Ste B. Henrico, VA 23228 Phone: (804) 591-0002 Fax: (804) 501-0101

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: _____ Client Phone #: _____

Client Date of Birth: _____ Last 4 digits of SSN: _____

Client Address: _____

_____

I hereby give Discovery Counseling & Consulting (DCC) authorization to:

☐ Release information to: ☐ Obtain information from:

Person/Provider/Company Name: _____

Relationship to Client: _____

Person/Provider/Company Address: _____

_____

Person/Provider/Company Phone Number: _____

Person/Provider/Company Fax Number: _____

Information Requested (please indicate all that apply):

☐ Intake/Assessment
☐ Progress notes
☐ Treatment summary
☐ Billing/Payment information
☐ Other (specify) _____

Purpose of Disclosure:

☐ Coordination of care
☐ Payment of services
☐ Insurance
☐ Legal or Disability
☐ Other _____

I understand that I may refuse to sign this Authorization and that DCC will not condition treatment on my agreeing to this Authorization unless the sole reason for treatment is to create health information to be disclosed to a third-party, in which case, failure to sign this Authorization may allow DCC to refuse to treat me or may prevent DCC from disclosing my health information to the intended third-party recipient. I also understand that I may request to receive a copy of the signed Authorization. I understand that information used or disclosed by DCC under this Authorization might be re-disclosed by a recipient and may, as a result, no longer be protected to the same extent to which it is protected by law while solely in the possession of DCC.

As the person signing this Authorization, I understand that this authorization will expire upon termination of my services with DCC unless otherwise indicated here: _____.
I also understand that I have the right to revoke this Authorization at any time, except to the extent that DCC has already acted pursuant to the Authorization.

_____

Printed Name of Client

_____ _____

Signature of Client/Responsible Party Date