New River Valley Community Services 700 University City BLVD Blacksburg, VA 24060

Client Name:

Date of Birth:

NRVCS MRN:

Authorization for Release of Protected Health Information

Date:

I, , hereby authorize New River Valley Community Services to disclose receive the following protected health information as indicated below (check all that apply):

Evaluations	Psychiatric Evaluations	VA Preadmission Screenings	Progress Notes
Psychiatric Treatment Notes	Treatment Plan	Treatment Plan Reviews	Discharge Summary
Listing of Services Provided	Lab Results	Drug Screen Results	Compliance Reports
Medication Summary	Other (specify)		

From within the following date parameters: All Dates From: To:

To (person or organization for which release is authorized above):

Name or Organization:

Address: City, State Zip:

Phone: Fax:

For the purpose of:

Treatment planning	Coordinate care	Report on progress	Referral for other treatment
Inform other of treatment status	Verify compliance	Legal consult/hearing	Determine disability
Vocational	At the request of the individual	Other (specify)	

I understand that the information authorized for release above may contain:

*Substance use treatment information *Co-occurring mental health treatment information that may include substance use treatment

Human Immune Deficiency Virus (HIV)/Aquired Immune Deficiency Syndrome (AIDS)-related information

* NOTICE: Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2), which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. 42 CFR Part 2 permits only limited disclosures regarding deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death.

As the individual signing this Authorization, I understand:

1. I am giving my permission to New River Valley Community Services to disclose my confidential health records.
2. That my signing of this Authorization is voluntary.
3. My health information is protected by federal HIPAA Privacy regulations.
4. If the organization authorized to receive the Information is not a health plan, healthcare clearing house or health care provider covered by federal privacy regulations, the released Information may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to redisclosure by the recipient(s).
5. Staff of New River Valley Community Services may not condition treatment, payment, or enrollment on the signing of this Authorization.
6. A photocopy of this Authorization is as valid as the original, and that I am entitled to a copy of this Authorization.
7. Paper or electronic copies of my records may be used to facilitate disclosure of my information.
8. I understand that I may see and receive a copy of the Information described on this Authorization if I request it in writing.
9. I understand that I have the right to refuse to sign this Authorization.
10. This consent expires automatically one year from the date signed, unless otherwise indicated below:

    This Authorization will expire on___________________(this date can be no more than one year from date of signature below).

11. I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it.

Client Signature DATE *Personal Representative Signature DATE

Client Printed Name Personal Representative Printed Name

NRVCS Staff Printed Name (If Applicable)

*Please see client record for evidence of the authority of the client's representative