Authorization to Obtain/Release of Information Consent Form

Patient: Date:

I hereby authorize VAMED Health Group to:

OBTAIN information from and/or

DISCLOSE information to the following:

Name of person/agency:

Address:

City: State: Zip:

Phone Number: Fax Number:

Information requested includes the following: (check all that apply)

Intake & Assessment Summary	Dates of Admission & Discharge	Speech/Hearing/Language Eval
Discharge Summary	Dates of Attendance in	Current School Adjustment
Psychiatric Evaluation	Summary for School	Psychological Testing
Medical Evaluation	Psychiatric Diagnosis Only	Medical Records
Progress Notes	Lab Data-Urinalysis Results	Educational Records
Treatment Plans	Drug Abuse or Alcohol Abuse	Other Records

Specify Other:

DESIGNATED RESTRICTIONS

This authorization is to disclose or obtain information for the following purpose(s):

Treatment planning, communication, management	Benefit determination
At request of individual (no statement/ purpose needed)	Discharge planning and referral
Court-related or legal	Case Review

Other (specify):

Type(s) of communication authorized:

☐ Written	☐ Fax	☐ Verbal	☐ Other (specify):

I understand that this information may be protected by Title 42 (Code of Federal Rules of privacy of Individual Identifiable Health Information, parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws, I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal laws.

I understand that refusal to sign this authorization form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by contacting my clinician, except to the extent that VAMED or the recipient acted on it prior to revocation, further understand that the confidentiality of psychiatric, drug/alcohol abuse and HIV record are protected under State and Federal laws and cannot be disclosed without my written consent unless otherwise provided for by law. The information disclosed by VAMED may be subject to further disclosure by the recipient all no longer protected by Federal law.

This authorization, if not cancelled, will expire on:

By signing below, I acknowledge that I have read and understand this authorization.

Patient Signature:

Date: