*Coastal Counseling Center, Inc.*
809 Kent Pl Chesapeake, Virginia 23320
757-436-0605 (Voice) 757-436-0023 (Fax)

# Authorization for Release of Protected Health Information

| **Patient Name:** | **Date of Birth:** |
|---|---|
| **Address:** | |
| **Phone Number:** | **Email Address:** |

*NOTE: Release of records will include sensitive information including mental health, alcohol or substance abuse, and HIV/AIDS.*

**I understand the following:**

-My treatment will not be impacted if I do not sign this release.
-Coastal Counseling Center cannot control how the recipient uses or shares the protected health being released. HIPAA or state laws that protect health information may not apply to the recipient.
-I can revoke this authorization upon written request. If I revoke, it will not affect information disclosed before the receipt of the written request.
-I have a right to review my health information before release.
-I have a right to receive a copy of this release.
-This authorization will expire **1 year** from the date signed **or Specific Date:**

| **PERMISSION TO SHARE:** I give my permission to share my protected health information. | |
|---|---|
| **FROM:** Coastal Counseling Center, PC | **TO:** ☐ Patient |
| Provider Name(s): | ☐ Person/Organization: |
| | **Send By:** ☐ Pick-up/Call when ready: |
| | ☐ Fax Number: |
| | ☐ Mailing Address: |
| | |
| ☐ On-going phone coordination-Phone # | |

**Fees: Virginia Code §.801-413. Allows for the following fees to *$20 + .50/page up to 50 pages then .25/page***

**This authorization will be used for:** ☐ Personal Use ☐ Insurance ☐ Social Security/Disability
☐ Medical Care ☐ Legal Matter ☐ Other (please specify)

**Information to be released:** ☐ Treatment Summary ☐ Complete Record
☐ Medication Management Notes ☐ Therapy Progress Notes ☐ Psychological Testing Report
☐ Partial Record/Other (specify)

**Patient Signature or Legal Representative** **Date**

**Printed Name** **Description of Authority to Act for Patient**