AUTHORIZATION FOR RELEASE OF INFORMATION

I_____ authorize _____of Midlothian Behavioral Health Associates, LLC.
(Name of Patient)

To release to/obtain from: _____

Address: _____

Phone Number: _____ Fax Number: _____

The following information from their records pertaining to (me, my child):

☐ ALL	☐ Medications	☐ Lab Results
☐ Progress Notes	☐ Medical/Physical Records	☐ Neurological Information
☐ Psychiatric Evaluation	☐ Substance Abuse Assessments	☐ Consumer's presence in treatment
☐ Psychological Evaluation	☐ Rehabilitative Services	☐ Discharge summary
☐ Developmental Information	☐ HIV/AIDS Information	☐ Other:_____

Dates of treatment/services: _____

Specific purpose or need for use/disclosure is: ☐ Diagnosis/Treatment ☐ Coordination of Care ☐ Other: _____

The mechanism used to disclose the information is noted as: ☐ Written ☐ Verbal

As a person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information. I further acknowledge that:

- I may refuse to sign this authorization
- I understand that treatment services are not contingent upon my decision concerning the signing of this release.
- This release is valid until noted otherwise.
- I have the right to revoke this authorization in writing at any time, but it is not retroactive to information already released in accordance to the authorization.

Date of Birth: _____ **Phone**: _____ **Last 4 of SSN**: _____

_____ _____ _____
Signature of individual or legally authorized representative Relationship **Date Signed**

_____ _____
Signature of minor (if required by law) Date signed