**AUTHORIZATION FOR RELEASE OF INFORMATION**

________________________________________ authorize ______________________________of Midlothian Behavioral Health Associates, LLC.
(Name of Patient)

☐ **Release to** ☐ **Obtain from**:___________________________________________________________________________

**Address**: ________________________________________________________________________________________

**Phone Number**: __________________________________ **Fax Number:** __________________________________

The following information from their records pertaining to me:

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

***Midlothian Behavioral Health Associates, LLC***
*14410 Sommerville Ct., Suite 101, Midlothian, VA 23113 Phone: 804-897-9355 Fax: 804-897-9359*
*www.midlothianwellness.com*