Afya Psychiatric Services

7639 Hull Street Road Suite 201
North Chesterfield, VA 23235

Authorization for Release of Information

Patient Information
Patient Name: _____ Date of Birth: _____

Person or Organization with Whom Information Can Be Shared
Provider: _____
Fax Number: _____

Date of Request: _____
(*Authorization is valid for 30 days from this date.*)

Information to Be Disclosed
[ ] Entire treatment record
[ ] Current status and location
[ ] Billing statements
[ ] Other: _____

Purpose of Disclosure
[ ] Continuity of care
[ ] Emergency management
[ ] Account management
[ ] Other: _____

Duration and Revocation of Authorization
This authorization is valid for 30 days from the date of request listed above.

- I understand that I may revoke this authorization at any time by submitting a written request to Afya Psychiatric Services, PLLC.
- I understand that any information already disclosed before revocation may not be retrievable.
- I understand that Afya Psychiatric Services, PLLC cannot condition treatment or benefits based on whether I sign this authorization, unless the information is required to determine eligibility for services or payment.

Authorization
I hereby authorize Afya Psychiatric Services, PLLC to release and/or request the information described above to/from the person or organization identified. I understand that the recipient may not be subject to HIPAA privacy laws and may further disclose the information.
I agree that my electronic signature is valid, legally binding, and has the same force as a handwritten signature.

Signed By (Print Name): _____
Signature: _____
Date Signed: _____

Relationship to Patient:
□ **Self / Patient**
□ **Authorized Representative (please specify): _____**