Release of Information Consent

** indicates a required field*

*** Client's name:**

*** Client's Address (City, State & Zip)**

*** Client's Phone Number & Email Address:**

*** I authorize [INSERT NAME OF MEDICAL PRACTICE or CLINICIAN'S NAME]**

*** [MEDICAL PRACTICE OR CLINICIAN'S ADDRESS & PHONE NUMBER]**

[MEDICAL PRACTICE OR CLINICIAN'S EMAIL]

* to:

- [ ] Send
- [ ] Receive

The following information:

- [ ] Medical history, medication and evaluation(s)
- [ ] Mental health evaluations
- [ ] Developmental and/or social history
- [ ] Educational records
- [ ] Progress notes, and treatment or closing summary
- [ ] Other

To/From:
Coping Matters PLLC / Davene Mathis, LCSW, LICSW
826 Caroline Street, Suite A, Fredericksburg, VA 22407

540-805-0066
davene.mathis@whycopingmatters.com

* Your relationship to client:

- ( ) Self
- ( ) Parent/legal guardian
- ( ) Personal representative
- ( ) Other

Your Address, Phone Number and Email:

* The above information will be used for the following purposes:

- [ ] Planning appropriate treatment or program
- [ ] Continuing appropriate treatment or program
- [ ] Determining eligibility for benefits or program
- [ ] Case review
- [ ] Updating files
- [ ] Other

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually 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 rules. I understand that this authorization is voluntary and that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. The information released in response to this authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires (Virginia CFR: §164.508(c)(2)(i-iii). I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

* **Signature:** _____

I consent to sharing information provided here.

*** Date:**

Witness signature (if client is unable to sign):

Witness Date: