Healing Journeys, LLC

25 Tinkling Spring Rd,
Fishersville, VA 22939
540-885-4787
admin@ourhealingjourneys.com

Release of Information

Authorization for the use and disclosure of Protected Health Information (PHI) is only for the person or agency on this form.

Name: DOB: SS#

I, , authorize

whose office is located at

to release/exchange by phone, fax, email or mail my PHI with:

Staff of Healing Journeys LLC, 25 Tinkling Spring Rd, Fishersville, VA 22939 5408854787

Reason for Disclosure:

The PHI to be disclosed includes the following:

- ✔ Assessment Information
- ✔ Diagnosis
- ✔ Treatment Planning Notes
- ✔ Progress & Treatment Notes
- ✔ Medication
- ✔ Recommendations
- ✔ Results of Psychological Testing
- ✔ Psychiatric Evaluation
- ✔ Reasons for Termination
- ✔ Other Substance Use/Mental Health

_____ Initial

For the purpose of:

- ✔ Collaboration
- ✔ Insurance
- ✔ Continued Care/Treatment
- ✔ Legal
- ☐ Other

Dates of records to be release:

Release will expire:

- ☐ End of 60 days
- ☐ Termination of treatment
- ✔ As of 05/01/2024

By signing below, I acknowledge that the above information about me may be released, discussed, or disclosed. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my therapist.

Client Signature Date

Parent/Guardian/Legal Representative Signature Date

Therapist/Provider Signature Date