BRIDGE TO WELLNESS CENTERS LLC
1934 Old Gallows Road, Suite 360
Vienna, VA 22182

Authorization for Use or Disclosure of Protected Health Information

Client Information

Last Name______________________ First Name ________________MI ___ DOB:___/___/____

Address
____

Home Phone: ________________________ Cell/Work Phone: ____________________

Eail Address: __________________________________

Recipient Information

I, _________________________, do hereby authorize _________________________ to release a copy of my mental health information to the person or facility below:

Name of person/facility to receive medical information: ______________________________

Phone: _______________________

Address: ____

Date of Authorization: ___/___/______
Authorization to expire on ___/___/______ or upon the happening of the following event: __________
____

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

( ) My entire mental health record

( ) Only those portions pertaining to:
____
(Specific provider name and/or dates of treatment)

( ) Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

Other: ____

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Purpose of Information Release:

( ) Further mental health care ( ) Payment of insurance claim ( ) Legal investigation
( ) Applying for insurance ( ) Vocational rehab, evaluation ( ) Disability determination
( ) At the request of the individual ( ) Other (specify): ____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

____ ____________________
Signature Date

If signed by a personal representative:

(a) Print your name: ____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: ( ) minor ( ) incompetent ( ) disabled ( ) deceased

Legal authority: ( ) parent ( ) legal guardian ( ) representative of deceased

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Client's Signature____
Print Name: ____
Date: _____________________