Suffolk Psychotherapy, Inc.

425 W. Washington St
Suite 4
Suffolk, Virginia 23434
Tel. (757) 809-5376
Fax (757) 401-6912

Patient's Full Name	Social Security Number	Date of Birth

I hereby authorize: _____

Name of Person or Organization Phone # Fax #

_____

Street Address City State Zip

To use/disclose/exchange the following healthcare information and records:

Intake/Referral	Diagnosis	Treatment Plan	Evaluation/Assessment	Psychological Evaluation
Physical Health	Medications	Progress Notes	Discharge Summary	Summary of Services Received
Social History	Transportation	Financial	Employment	Title IV-E Eligibility
Participation & Attendance		Substance Abuse	Infectious Diseases: AIDS, HIV, TB	

Other: _____

To/With:

Suffolk Psychotherapy, Inc. 425 W. Washington St., Suffolk, VA 23434

Purpose of use/disclosure/exchange of information is: (Check all that apply) Assessment Treatment Discharge Planning Benefits/Service Eligibility Coordination of care Legal Other: _____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I want all persons and organizations to accept a copy or faxed version of this form as a valid authorization to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need. I understand that:

- Suffolk Psychotherapy, Inc. cannot condition treatment or payment on my willingness to sign this authorization. I may refuse to sign this authorization.
- This authorization will become effective upon the date signed below unless noted otherwise.
- Only the information needed to satisfy the stated purpose of this disclosure will be shared. I understand this will include information added after the authorization origination date and up until the authorization expiration date.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records. *(Use "Revocation of Authorization to Disclose Confidential Information" (HIPAA 008).*
- A copy of this authorization and a notation concerning the persons or agencies to which disclosure was made shall be included with my original health records.
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR Part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- Suffolk Psychotherapy, Inc., and/or its employees are hereby released from any legal responsibility or liability for disclosing information as I have authorized by completing this form, or for the use of information by the person or organization receiving it.

Unless revoked, this authorization will expire: in 365 days (one year) or Other (specify date or event): _____

_____

Patient's signature Date

_____

Parent/Guardian/Authorized Representative's signature, when required Date

Witness signature optional, unless consumer's signature is a "mark" _____Date_____

I do not wish to sign this authorization at this time _____*(insert initials if you do not wish to sign authorization*)