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

Additional Information to disclose: _____

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.

This Authorization will not expire unless it has been revoked in writing by myself.

_____

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*)