Client Name: _____
Date of Birth: _____

Christian Life Counseling of SWVA
602 Radford Street, Christiansburg, VA 24073
Phone 540-382-1751 Fax 540-382-1740

Authorization for Release of Protected Health Information	**Date:**

I, _____, hereby authorize Christian Life Counseling of SWVA (independent providers Lisa Pugh, LPC, Kimberly Price, LPC & Tiffany McCann-Vaught, LPC) to
☐ disclose ☐ receive the following protected health information as indicated below (check all that apply):
☐ Evaluations ☐ Psychiatric Evaluations ☐ VA Preadmission Screenings ☐ Progress Notes
☐ Psychiatric Treatment Notes ☐ Treatment Plan ☐ Treatment Plan Reviews ☐ Discharge Summary ☐ Listing of Services Provided ☐ Lab Results ☐ Drug Screen Results ☐ Compliance Reports ☐ Educational records
☐ Medication Summary ☐ Other (specify): _____

From within the following date parameters: ☐ All Dates ☐ From: _____ To: _____
To (Person or Organization for which release is authorized above):

Name of Organization: _____
Address : _____ City, State, Zip: _____
Phone: _____ Fax: _____

For the purpose of:
☐ Treatment Planning ☐ Coordinate Care ☐ Report on Progress
☐ Referral for other treatment ☐ Verify Compliance ☐ Legal consult/hearing
☐ Determine Disability ☐ Vocational ☐ At the request of the individual
☐ Other (specify): _____

I understand that the information authorized for release above may contain:
☐ * Substance use treatment information
☐ * Co-occurring mental health treatment information that may include substance use treatment
☐ Human Immune Deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) related Information
*** NOTICE: Information approved for disclosure based on this authorization may be protected by Federal Regulations (42 CFR Part 2,) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or their legal representative or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. 42 CFR Part 2 permits only limited disclosures regarding deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into cause of death.**

<u>As the individual signing this Authorization, I understand:</u>
I am giving my permission) Christian Life Counseling of SWVA (independent providers Lisa Pugh, LPC, Kimberly Price, LPC & Tiffany McCann-Vaught, LPC,) to disclose/receive my confidential health records. That my signing this Authorization is voluntary. My health information is protected by federal HIPPA Privacy regulations. If the organization authorized to receive the Information is not a health plan, healthcare clearing house or health care provider covered by federal privacy regulations, the released Information may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to redisclosure by the recipient(s). Christian Life Counseling of SWVA (Lisa Pugh, LPC, Kimberly Price, LPC & Tiffany McCann-Vaught, LPC) may not condition treatment, payment, or enrollment on the signing of this Authorization. A photocopy of this Authorization is valid as the original, and that I am entitled to a copy of this Authorization. Paper or electronic copies of my records may be used to facilitate disclosure of my information. I understand that I may see and receive a copy of the Information described on this Authorization if I request it in writing. I understand that I have the right to refuse to sign this Authorization.
This consent expires automatically one year from the date signed, unless otherwise indicated below:

☐ This Authorization will expire on_____ (this date can be no more than one year from the date of the signature below).

I may revoke this consent at any time by signing and dating a formal request, except to the extent that action has already been taken in reliance upon it.

_____ _____ _____
Client/ parent/ guardian Signature **client/parent/guardian printed name** **Date**

_____ _____
Counselor **Date**