AUTHORIZATION FOR USE/DISCLOSURE/EXCHANGE OF PROTECTED HEALTH INFORMATION

DBHDS/Western State Hospital, P.O. Box 2500, Staunton, VA 24402-2500
Telephone Number : (540) 332-____8015_____ Fax Number: (540)332-8266 _____

Patient Name: Last, First, MI | **DOB:**

Extent or nature of use/disclosure is limited to: (Check √ or list all that apply)

☐ Discharge Summary	☐ History & Physical	☐ Social Work Assessment
☐ Psychiatric Evaluation	☐ Progress Notes	☐ Physician Orders
☐ Lab Work	☐ Consultations	☐ Treatment Plan
☐ HIV/AIDS Information	☐ Substance Abuse Information	☐ Psychological Assessment/Integrated Summary

☐ Other: List All: _____

Specified purpose or need for use/disclosure is: ☐ Diagnosis/Treatment ☐ Discharge Planning ☐ Other, Specify

Permission is hereby given to: Facility Name & Name of Responsible Person e.g. ("Facility director or his authorized designee")	Western State Hospital: (Insert name of Person Responsible) Krista DeVore, Health Information Management
☐ **To disclose information to OR** ☐ **To exchange information with:** Name or other specific identification and organization Street Address, City, State, Zip Phone/Fax #	**Phone:** **Fax:**

I also authorize the recipient to use the information received pursuant to this authorization.

As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information. I further acknowledge that:

- I may refuse to sign this authorization.
- DBHDS / Western State Hospital cannot condition the provision of treatment to me on my signing of this authorization.
- The original or a copy of this authorization shall be included with my original records.
- 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.
- 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.

If not previously revoked, this authorization will expire in:	☐ 90 Days	☐ One Year	☐ On (specify date or event)
The information may be disclosed effective:	☐ Immediately	☐ (specify date)	

This authorization ☐ does ☐ does not extend to information placed in my record after the date I signed this form.

Please also complete Relationship and Date Signed

SIGNATURE of Individual (adult) or Authorized Representative	Relationship	Date Signed
SIGNATURE of Minor (if required by law)		Date Signed
SIGNATURE of Witness (optional)		**Date Signed**

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