Southside Counseling Center, LLC
PO Box 2387, 6072 Godwin Blvd.
Suffolk, VA 23432

757-255-2555 (OFFICE) 757-255-7009 (FAX)

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I _____ DOB:_____

Authorize (Name):_____Phone:_____

Address:_____

Telephone: _____ Fax:_____

PLEASE INITIAL: _____ To disclose the following information and/or

_____ Receive the following information:

_____ All medical records from (dates)_____ to: _____

Including: In-Patient and Out-Patient doctor's notes. I understand that medical records include: diagnosis, prognosis and treatment medication history.

_____All Laboratory Tests, Diagnostic tests and Pathological Tests

_____Verbal Exchange of Information Only

_____Psychological Testing and Psychotherapy Notes

_____Billing, Insurance and Payment Information

Other (Please Specify) _____

TO/FROM: Southside Counseling Center, LLC
P.O. Box 2387, 6072 Godwin Blvd.
Suffolk, VA 23432
(757) 255-2555 (Office) (757)255-7009 (Fax)

Purpose of Release:_____Continuity of Care_____Legal Representation_____

Education Purposes:_____ Disability_____Other: (Specify)_____

I have been informed that the requestor will not release any information about me to any person or agency other than those stated above. I understand that I may revoke this authorization any time, except to the extent that the action has already been taken.

This consent shall stay valid until _____ and will expire without further notice or condition**. I understand that I have been informed that I have a right to receive a copy of this authorization and acknowledge receipt of the same if so demanded** _____(initial)

I understand, that the information released to or from Southside Counseling Center may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and or AIDS or physical conditions. _____(initial)

DRUG AND ALCOHOL TREATMENT

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records. 42 C.F.R Par 2 and Health Insurance Portability Accountability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160-164 and cannot be disclosed without my written consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires as follows:

Patient Signature:_____Date:_____

I certify that this authorization is made voluntarily. I understand the information released is protected under state and federal law and cannot be re-disclosed without further written consent, unless provided for by state and federal law.

Date:_____ Print Name:_____

Witness:_____ Signed:_____

(Patient, Legal Guardian or POA)

To Whom it may Concern: The Federal Privacy Act of 1974 (P.L. 93-579) and other government regulations have heightened the need for security in the transfer of privileged communications. The information you request will be records whose confidentiality is protected by those regulations and prohibit anyone from making further disclosure of it without written consent of the person to whom it pertains or as otherwise permitted by such regulation.