Goochland Powhatan COMMUNITY SERVICES Connect. Grow. Thrive.

AUTHORIZATION TO RELEASE INFORMATION

I, _____ *(consumer)*, _____ *(DOB)*, authorize Goochland Powhatan Community Services to __ request from and/or __ disclose to:
Name of entity and/or individual: _____
Address: _____
Phone: _____ *Fax*: _____ *Email*: _____
the following protected health information:

__ Evaluation/Assessment
__ Treatment
__ Medication(s) Prescribed
__ General Physical Health
__ Infectious Disease: AIDS, HIV, TB, Other
__ Information related to an Emergency
__ Psychological Evaluation/Testing
__ Financial Information
__ Discharge Summary
__ Photographs, videos, digital, or other images

Substance Use Information to Request/Disclose:
__ Substance Use Diagnosis
__ Medications for Substance Use
__ Lab Results related to Substance Use
__ History of Substance Use
__ Participation in services for Substance Use
__ Referral for/to Substance Use services

__ Other (Specifically and meaningfully describe the protected health information to be disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.):

_____

This protected health information is being requested and/or disclosed for the following purposes:
__ At the request of the individual __ Assessment __ Coordination of care __ Emergency contact
__ Other, Specify: _____

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. This consent will expire 30 days after my discharge date, unless otherwise specified: _____

GPCS will not condition my treatment, payment, or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I have been provided a copy of this form.

_____ _____
Signature of Consumer or Personal Representative Date

_____ _____
Print Name of Consumer or Personal Representative Description of Personal Representative's Authority

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Please forward requested information or correspondence to the attention of

_____

__ PO Box 189
Goochland, Virginia 23063
804-556-5400 phone
804-556-5403 fax

__ 3910 Old Buckingham Road
Powhatan, Virginia 23139
804-598-2200 phone
804-598-3114 fax

ELECTRONIC COMMUNICATION RELEASE

My signature below indicates that I am allowing GPCS to communicate via email with the entity noted on this document. I understand that though GPCS will only use encrypted email to send PHI, there are inherent risks in using email.

- Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Recipients can forward email messages to other recipients without the original sender's permission or knowledge.
- Users can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email may exist even after the sender or the recipient has deleted their copy.
- Email containing information pertaining to diagnosis and/or treatment of a person served is not a part of the medical record.
- All email may be discoverable in litigation regardless of whether it is in an individual's medical records.

<u>Please note: Email is not a substitute for treatment nor is it to be used for emergency situations.</u>
I am authorizing electronic communication for reasons that, for me, outweigh the risks of using electronic means for sharing information. I understand that I can revoke either this email communication release or this entire release of information at any time.

_____ _____
Signature of Consumer or Personal Representative Date

_____ _____
Print Name of Consumer or Personal Representative Description of Personal Representative's Authority