Goochland Powhatan COMMUNITY SERVICES Connect. Grow. Thrive.

AUTHORIZATION TO RELEASE INFORMATION

Consumer Name _____ Consumer ID _____ 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.
- Information disclosed by this authorization may be re-disclosed by the recipient and would no longer be protected by federal privacy regulations.
- 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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COMMUNITY SERVICES
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AUTHORIZATION TO RELEASE INFORMATION

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