Clinch River Health Services
Authorization for Use/Disclosure of Protected Health Information

Full Legal Name:						
DOB:		SSN:				
I Authorize:	**Clinch River Health Services**					
Address:	**17285 Veterans Memorial Hwy**		**Dungannon, VA 24245**			
Telephone #	**(276) 467-2201**	Fax #	***(If file is to large please mail)*** **(276) 467-2673 Please fax to this # only**			
☐ To disclose information to: **AND/OR** ☐ To receive information from:	Name of Agency/Facility To Receive/Exchange Info:					
	Address:					
Telephone #		Fax #				

Description of information requested for disclosure/exchange:

☐Lab Results	☐X-Ray	☐Screening	☐Crisis Stabilization
☐Progress Notes	☐History and Physical	☐Substance Abuse Info	☐Assessments
☐Medical Information	☐Pap	☐Psychological Evaluation	☐Discharges/Case Closures
☐Medication Sheet	☐Immunizations	☐Psychiatric Information	☐All
☐Eye Exam	☐Other (list) Click or tap here to enter text.		

PLEASE NOTE THAT ANY DOCUMENTATION IN THE TREATMENT RECORD THAT CONTAINS INFORMATION ABOUT THE DIAGNOSIS AND/OR TREATMENT OF HIV/AIDS REQUIRES ADDITIONAL AUTHORIZATION. WITH MY SIGNATURE/DATE, HERE._____ I AM ALSO AUTHORIZING THE RELEASE OF THIS INFORMATION.

At the request of patient or personal representative? ☐ Yes ☐ No (if no, please explain) _____

As the person signing this authorization, I acknowledge that I am giving permission to CRHS to disclose/exchange protected health information. I further acknowledge that:

- I may refuse to sign this authorization.
- Clinch River Health Services will not condition treatment on my signing of this authorization.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, by notifying the providing organization in writing. There is a potential for any information disclosed/exchanges pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPPA Privacy Rule.
- If this information is being disclosed/exchanged from records protected by the Federal Substance Abuse confidentiality rules (42 OFR, Part 2), the Federal rules prohibit the recipient from making any further disclosure/exchange of this information unless further disclosure is expressly permitted by my written authorization or as otherwise permitted by 42 CFR Part 2. A general authorization for this disclosure/release of medical or other information is NOT sufficient for this purpose.
- This information will be shared with those individuals in the criminal justice system who have a need for the information in connection with their duty to monitor my treatment.
- I understand that under Virginia statute I may pay a reasonable cost based fee that includes the cost of supplies and labor. Postage is an additional charge. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

Is this authorization limited to a Single Disclosure/Exchange? ☐ Yes ☐ No If No, this authorization will expire in: ☐ One year.
This information may be disclosed/exchanged effective: ☐ Immediately ☐ Other (please specify date/event)
This authorization ☐ Does ☐ Does not extend to information placed in my record after the date I signed this form. Is there any information that you do not want released? ☐ Yes ☐ No If yes. please list
DO NOT SIGN THIS FORM UNLESS ALL SECTIONS ARE COMPLETE, AND YOU AGREE THAT IT IS ACCURATE

Patient's Signature		Date:	
☐Authorized Representative ☐Guardian ☐Parent Signature		Date:	
Minor's Signature (if required by law)		Date:	
Patient or Authorized Representative was given a copy of this authorization: ☐Yes ☐Refused			
FOR OFFICE USE ONLY			
Date Requested Filled:		By:	☐