HIPAA Release Form - Virginia

Patient's full name:

Date of birth:

Patient's address:

Patient's contact information:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, and **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION** only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize the release of such information to the person(s) indicated in Item 6.

2. With some exceptions, health information, once disclosed, may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the ____________________________________ at ___________________________. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally, my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

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6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

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____

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7. Reason for the release of information:

____

8. Unless previously revoked by me, the specific information below may be disclosed from:

________________ (start date) until _________________ (validity end date)

☐ - All health information (written and oral)

☐ - All health information (written and oral), except:

____

For the following to be included indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, the name of the person signing the form:

____

10. Authority to sign on behalf of the patient:

____

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

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SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

Date signed: ____________________________