genesis
COUNSELING CENTER

☐Authorization to Release/Exchange Protected Health Information ☐Request for Records

I, ______________________________________ (Name of Client) (DOB: ___/___/___) voluntarily authorize Genesis Counseling Center to use and disclose the protected health information described below to:

____
(Name, address and phone number of person or organization to whom information will be released)

☐I authorize Genesis Counseling Center to verbally communicate regarding my treatment with the above person or organization, subject to the following limitations: ____

☐I authorize Genesis Counseling Center to release my complete health record with the exception of the following information:
____

☐I request the release of my complete health record be sent to Genesis Counseling Center (fax: 757-838-2573.) Request from:
____

This authorization for release of information covers health records for the period of ☐_____________ to _____________ or

☐ all past, present, and future periods.

The purpose or need for this disclosure is:

☐Care Coordination ☐Personal Use ☐Attorney ☐School ☐Other (specify):___________________________

I understand the following:

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- I understand that I may be denied services if I refuse to consent to disclosure for the purposes of treatment, payment, or healthcare operations. I will not be denied services if I refuse to authorize disclosure for other purposes.
- I understand that I have the right to revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance on it. Unless I revoke my authorization earlier, this authorization shall expire as follows ____(date, event, or condition)
- I understand that my substance use disorder records (if any) 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 information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I have been provided a copy of this form.

____ ____________________
Signature of client or personal representative Date

____ _________________________
Printed name of client or personal representative and his/ her relationship to client Client/Guardian contact number

Individuals requesting their own records will be charged a reasonable, cost-based fee for paper or electronic copies. Third parties requesting records (including attorneys) will be assessed a reasonable charge as permitted by Virginia law, including a search and handling fee not to exceed $20, $0.50 per page for up to 50 pages and $0.25 per page thereafter for paper for hard copies, $0.37 per page for up to 50 pages and $0.18 per page thereafter for paper for electronic copies, plus all postage and shipping costs (not to exceed a total of $150 for electronic copies). Genesis Counseling Counseling Center has 30 days to process this request. This fee must be paid in full prior to release.

Revised: 2/8/2019