BALDWIN COUNSELING

REQUEST FOR RELEASE OF MENTAL HEALTH RECORD

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____,

authorize Suzanne Baldwin and/or Baldwin Counseling obtain records for myself

_____ or my child _____from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Received

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____Other_____

OR

_____ Entire Treatment Record

OR

_____ Specify Dates of Service

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Baldwin Counseling at 2832 South Lynnhaven Road, Suite 102, Virginia Beach, VA 23452. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records, if requseted.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date