Whole Village Counseling, Advocacy, and Mental Health Services, LLC
5316 Patterson Avenue, Suite 108
Richmond, VA 23226
Phone: (804) 859-4002 Fax: (804) 859-4009

Service Recipient's Full Name	Social Security Number	Date of Birth

I hereby authorize: Whole Village Counseling, Advocacy, and Mental Health Services, LLC (757) 255-8175 (804) 859-4009
Name of Person or Organization Phone # Fax #

All Locations
Street Address City State Zip

to use/disclose/exchange the following healthcare information and records: (Check all that apply)

☐ Intake/Referral	☐ Diagnosis	☐ Treatment Plan	☐ Evaluation/Assessment	☐ Psychological Evaluation
☐ Physical Health	☐ Medications	☐ Progress Notes	☐ Discharge Summary	☐ Summary of Services Received
☐ Social History	☐ Transportation	☐ Financial	☐ Employment	☐ Results of Drug Screens
☐ Participation & Attendance		☐ Substance Abuse	☐ Infectious Diseases	☐ All of the Above

Other: _____

To/With:
Name of Person or Organization Phone # Fax #

Street Address City State Zip

The purpose of use/disclosure/exchange of this information is at the request of the individual. (*If no specific purpose is selected, the records that are requested, per the request of the individual signing this form, will be released for general use)*:
(Check all that apply) ☐ Assessment ☐ Treatment ☐ Discharge Planning ☐ Benefits/Service Eligibility
☐ Coordination of Care ☐ Legal ☐ Other: _____

Dates of Service for Information: ☐ All Service Dates / / to / /

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I want all persons and organizations to accept a copy or faxed version of this form as a valid authorization to share information. If I do not sign this form, information will not be shared, and I will have to contact each agency individually to give them information about me that they need. I understand that:

- Whole Village Counseling, Advocacy, and Mental Health Services, LLC cannot condition treatment or payment on my willingness to sign this authorization. I may refuse to sign this authorization.
- This authorization will become effective upon the date signed below unless noted otherwise.
- Only the information needed to satisfy the stated purpose of this disclosure will be shared. I understand this will include information added after the authorization origination date and up until the authorization expiration date.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records.
- A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR Part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- Whole Village Counseling, Advocacy, and Mental Health Services, LLC , its employees, agents, contractors, and Board, are hereby released from any legal responsibility or liability for disclosing information as I have authorized by completing this form, or for the use of information by the person or organization receiving it.

Unless revoked, this authorization will automatically expire in 365 days (one year), unless indicated by checking *Other*,

☐ **Other (specify date or event):** _____

Service Recipient's signature Date

Parent/Guardian/Authorized Representative's signature, when applicable Date

Staff signature Date