



Coastal Counseling Center, PC
809 Kent Pl Chesapeake, Virginia 23320
757-436-0605 (Voice) 757-436-0023 (Fax)

Authorization for Release of Protected Health Information

Patient Name:	Date of Birth:
Address:	
Phone Number:	Email Address:

NOTE: Release of records will include sensitive information including mental health, alcohol or substance abuse, and HIV/AIDS.

I understand the following:

- My treatment will not be impacted if I do not sign this release.
- Coastal Counseling Center cannot control how the recipient uses or shares the protected health being released. HIPAA or state laws that protect health information may not apply to the recipient.
- I can revoke this authorization upon written request. If I revoke, it will not affect information disclosed before the receipt of the written request.
- I have a right to review my health information before release.
- I have a right to receive a copy of this release.
- This authorization will expire **1 year** from the date signed **or Specific Date:**

PERMISSION TO SHARE: I give my permission to share my protected health information.	
FROM: Coastal Counseling Center, PC	TO: ☐ Patient
Provider Name(s):	☐ Person/Organization:
	Send By: ☐ Pick-up/Call when ready:
	☐ Fax Number:
	☐ Mailing Address:
☐ On-going phone coordination-Phone #	

Fees: Virginia Code §.801-413. Allows for the following fees to \$20 + .50/page up to 50 pages then .25/page

This authorization will be used for: ☐ Personal Use ☐ Insurance ☐ Social Security/Disability
☐ Medical Care ☐ Legal Matter ☐ Other (please specify)

Information to be released: ☐ Treatment Summary ☐ Complete Record
☐ Medication Management Notes ☐ Therapy Progress Notes ☐ Psychological Testing Report
☐ Partial Record/Other (specify)

Patient Signature or Legal Representative

Date

Printed Name

Description of Authority to Act for Patient