AUTHORIZATION/CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT NAME	DATE OF BIRTH:

I AUTHORIZE: Northern Virginia Older Adult Counseling, LLC
10615 Judicial Dr., Suite 301, Fairfax, VA 22030

TO DISCLOSE: Any and all of the medical and financial records pertaining to the treatment of the client seen by this practice.

[ ] I understand that I am giving permission to disclose confidential health records that may contain behavioral health services, mental health services, and/or psychotherapy notes.

AUTHORIZED INDIVIDUAL(S)/INSTITUION(S):

Name:	Address:	Phone Number:	Relationship:

FOR THE FOLLOWING PURPOSE(S):

[ ] Continued Care [ ] Insurance Claim [ ] Personal Use [ ] Attorney Review
[ ] Other _____

I understand that I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I revoke this authorization, I agree to do so in writing and present my written revocation to

Northern Virginia Older Adult Counseling, 10615 Judicial Dr., Suite 301, Fairfax, VA 22030.

This authorization will automatically expire on: _____/_____/_____ or one (1) year from the date of my signature below.

I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

I certify that I am the client or the client's legal guardian, with the authority to authorize disclosure of this client's protected health information.

_____

SIGNATURE OF CLIENT/LEGAL GUARDIAN DATE

_____

RELATIONSHIP TO PATIENT/LEGAL AUTHORITY