Mount Rogers
COMMUNITY SERVICES

770 West Ridge Rd
Wytheville, VA 24382

276-223-3200

mountrogers.org

Individual's Name:

Individual's DOB

Authorization to Disclose

Full name of person(s) authorizing disclosure of Protected Health formation

authorize(s) Mount Rogers Community Services *

- ☐ To disclose to
- ☐ Exchange with
- ☐ Obtain from

Name of person or agency (A Consent Service must be done for each person or Agency that request information!)*

Information to be disclosed [check all that apply]*

- ☐ Treatment Plan
- ☐ Summary of Services Received
- ☐ Summary of Participation/Attendance
- ☐ Medication(s) Prescribed
- ☐ Diagnosis
- ☐ Evaluation/Assessment
- ☐ Psychological Evaluation
- ☐ Progress Notes
- ☐ Social History
- ☐ Substance Abuse/Use History
- ☐ Family/Social History
- ☐ Criminal Justice Records
- ☐ Permission to see individual Face to Face in the school setting
- ☐ Employment History/Performance
- ☐ Urine Drug Screen Results
- ☐ Education Records
- ☐ Discharge Summary
- ☐ General Health/Physical Exam
- ☐ Labs / Diagnostic Studies
- ☐ Infant Screening Results
- ☐ Insurance/Billing/Financial
- ☐ Intake/Referral/Screening
- ☐ Urine Drug Screen Results
- ☐ Labs/Diagnostic Studies
- ☐ Employment History / Performance
- ☐ Other:

Substance Use Specific

I authorize MRCSB to disclose the Substance Use Information contained in the following items checked above:*

- [ ] None
- [ ] Treatment Plan
- [ ] Summary of Services Received
- [ ] Summary of Participation/Attendance
- [ ] Evaluation/Assessment
- [ ] Psychological Evaluation
- [ ] Progress Notes
- [ ] Social History
- [ ] Family Social History
- [ ] Criminal Justice Records
- [ ] Employment History / Performance
- [ ] Education Records
- [ ] General Health / Physical Exam
- [ ] Financial and Insurance Information
- [ ] Intake / Referral
- [ ] Medications relating to SUD treatment
- [ ] Diagnosis relating to SUD
- [ ] Lab Results, including Urine Drug Screen Results
- [ ] Discharge Summary
- [ ] Other

- [ ] **I do not authorize MRCSB to disclose any Substance Use Information contained in my record.**

Disclosure may include [Check all that apply]

- [ ] AIDS or HIV related information
- [ ] Other Infectious Diseases (such as TB, Hepatitis, etc.)

Purpose of disclosure*

- [ ] Assessment
- [ ] Follow-up Care
- [ ] Ongoing Treatment
- [ ] Eligibility Determination
- [ ] Service Coordination & Treatment Planning
- [ ] Medication Authorization
- [ ] Other [specify]

As the person signing this Authorization to Disclose Protected Health Information, I understand that I am giving permission for Mount Rogers Community Services Board to release or obtain and use confidential health information. I understand that treatment, payment, enrollment or eligibility for benefits is not affected by signing this form. I understand that I may refuse to sign this Authorization. I also understand that the information disclosed may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations and may no longer be protected by state law. This Authorization will be included in my service record and a copy will be provided to me.

I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken in reliance on it. I will notify Mount Rogers CSB in writing of my desire to revoke this Authorization; my revocation is not effective until delivered in writing to the person in possession of my records. I understand this Authorization extends to information placed in my record after the date I signed this Authorization, unless otherwise requested.

Unless otherwise revoked, this Authorization will expire in*

☐ 90 days from date of my signature (**You must put date in calendar box!**)

☐ 365 days (one year) from date of my signature (**You must put date in calendar box**)

☐ Discharge date

**** Authorization must be signed by the individual or authorized representative.**

**** Authorization must be signed by the individual or authorized representative.**

Note: This information may be protected by federal regulations concerning alcohol and drug abuse patient records (42 CFR, Subchapter A, Part 2), which prohibit recipient from making any further disclosure of alcohol or substance abuse treatment information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose. These regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This Authorization requires the individuals or authorized representatives signature.

A copy of this Authorization must be given to the individual or authorized representative.

_____

Staff Signature

_____

Individual's Signature