FARLEY CENTER / WILLIAMSBURG PLACE
5477 Mooretown Road - Williamsburg, VA 23188
(757) 565-0106 (800) 582-6066 FAX (757) 565-0620

AUTHORIZATION TO RELEASE AND / OR OBTAIN PROTECTED HEALTH INFORMATION

I,____, Date of Birth:_______________, Social Security Number: _________________________________,

authorize the Williamsburg Place/ William J. Farley Center to exchange information with: Phone Number: _________________________________

PLEASE PRINT
Individual: _______________________________________ ( ) Therapist ( ) Employer

Agency: _________________________________ ( ) Aftercare ( ) EAP

Address: _______________________________________ ( ) Physician ( ) Referral Source

_______________________________________ ( ) ____________________ ( ) Family (Relationship)_____________________

Phone Number: _______________________________________Fax: _______________________________ ( ) Best time to call Family member___________

For the purpose of ____ ____.

I understand that information disclosed or discussed may include details about my assessment information, diagnosis, treatment, progress in treatment, prognosis, and ongoing treatment needs.

PATIENT INITIAL	RELEASED	PATIENT INITIAL	OBTAINED
( ) Discharge Summary		( ) Discharge Summary	
( ) Continuing Care Contract/Plan		( ) Continuing Care Contract/Plan	
( ) Integrated History and Physical		( ) Integrated History and Physical	
( ) Psychosocial Assessment		( ) Psychosocial Assessment	
( ) Psychological Evaluation		( ) Psychological Evaluation	
( ) Physician's Orders		( ) Physician's Orders	
( ) Laboratory Reports		( ) Laboratory Reports	
( ) Evaluation/Assessment		( ) Evaluation/Assessment	
( ) Verbal Communication		( ) Verbal Communication	
( ) FAMILY PROGRAM Verbal & written communications ( ) Family Input Questionnaire		( ) FAMILY PROGRAM Verbal & written communications ( ) Family Input Questionnaire	
( ) Other:		( ) Other:	

Drug/Alcohol Abuse Information is confidential and protected by Federal Law. This consent is subject to patient revocation at any time except to the extent that action has already been taken. If not previously revoked, this consent will expire on ________________, ***(Specify Date or Event)*** or 120 days from the date signed, whichever is earlier.

I hereby authorize the facility to use and disclose my individual identifiable Protected Health Information ("PHI") in the manner described above. I understand that my PHI may not be re-disclosed by the person or entity receiving my PHI according to federal privacy regulations. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by written notification. I understand that my revocation or modification of this authorization will not affect any actions taken by the facility in reliance on this authorization before it receives my request for revocation or modification. I must sign my written request and send to the above address.

Signature of Patient: ____ Date: ________________________________

If not signed by patient, please print name and indicate relationship: ____

Signature of Witness: ____ Date: _________________________________