Psychiatric Associates of Northern Virginia
4229 Lafayette Center Dr.
Suite 1760
Chantilly, VA, 20151
Office phone:571-306-7919 fax: 571-306-7802

Authorization to release and obtain confidential information

Name:_____ **Date of Birth:**_____

(Psychiatric Associates of Northern Virginia does not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization to release and obtain confidential information)

I authorized Psychiatric Associates of Northern VA ☐ Exchange with ☐ Obtain from ☐ Disclosed to
Organization and / or Name and Title: _____

Address: _____

☐Social history ☐diagnostic evaluation ☐service plan ☐treatment summary

☐Discharge summary ☐progress notes ☐medical records ☐Substance use info

☐HIV/AIDS/STD status ☐third party information ☐other

For the following purpose(s):_____

This consent☐includes or ☐does not include information placed in my records after the date of signature below.

I understand that:

- My records are protected under federal or state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.
- I may revoke this consent in writing at any time,except to the extent that action has been taken in reliance on it.
- If I am participating in this program as a condition of probation, parole, or released from confinement, I may not revoke the consent for unlimited communication between Psychiatric Associates of Northern VA in the criminal justice system until financial disposition of my case.
- When I authorize the Psychiatric Associates of Northern VA to disclose information to third parties, we are unable to prevent re-disclosure of this information by the recipient.
- The information to be released was fully explained to me and this consent is given of my own free will.

This consent expires as described:_____
(Date, event, or condition upon which this consent will expire)

Signature of patient:_____ Date:_____

Signature of authorized representative (if applicable)_____ Date:_____

☐Parent ☐Guardian ☐legally authorized representative ☐other

NOTE: Where substance abuse diagnosis/treatment information accompanies this disclosure form: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of 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. This authorization does not authorize you to Re-release disclosed any information to third parties.