Crossroads Counseling Center, Inc.

AUTHORIZATION TO ACQUIRE/DISCLOSE/EXCHANGE PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Phone # _____ SSN or Medicaid #: _____

I hereby authorize Crossroads Counseling Center, Inc. to acquire from, disclose to, or exchange my protected health information with:

Name of Individual: _____

Company/Agency Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax No.: _____

I understand that any information acquired, disclosed or exchanged may include information relating to behavioral or mental health services, treatment for alcohol and drug abuse, Sexually Transmitted Diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) and may include information obtained by Crossroads Counseling Center, Inc. from other providers.

I authorize the following information to be ☐ acquired from ☐ disclosed to ☐ exchanged with the Individual/Agency listed above:

☐ Psychiatric Evaluation/Assessment ☐ Medical and Medication Records, Physical Exam ☐ Service/Treatment Plan
☐ Monthly Summaries ☐ Discharge Summary ☐ School records (acquire only) ☐ Alcohol/Substance Use Information
☐ Other (specify): _____

For the Dates of Service:

☐ From (date) _____/_____/_____ to (date) _____/_____/_____
☐ Most Recent Only
☐ ANY - I do not recall the specific dates of service.

The information will be used for the following purpose(s):

☐ Assessment/Diagnosis ☐ Evaluation of service eligibility and needs ☐ To develop a treatment plan
☐ On-going treatment and service coordination ☐ Follow-up care ☐ Give permission for Psychological Testing
☐ Other (specify): _____

This Authorization is effective:

☐ As of the date of my signature and will expire on (date) _____/_____/_____ *(not to exceed one year),* **OR**
☐ Until all services have been received and I have been discharged from services with CCC and follow-up care completed, **OR**
☐ Until the specified information has been received or disclosed, as requested *(for one time release of information)*.

Acknowledgement:

By signing this Authorization, I acknowledge that I have given permission to the above named persons/class of persons to acquire from, disclose to and/or exchange protected health information with Crossroads Counseling Center, Inc. I understand that authorizing the disclosure of this protected health information is voluntary and I can refuse to sign this form. Crossroads Counseling Center, Inc. will not withhold treatment should I refuse to sign. I understand there is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rules. I understand that I have the right to limit what is disclosed. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR Part 2), I understand that the Federal rules prohibit the recipient from making any further re-disclosure of this information unless a written authorization is obtained from me or as otherwise permitted by 42 CFR Part 2. I understand that I have the right to revoke this Authorization at any time prior to expiration by sending a written notice to the Crossroads Counseling Center, Inc. location identified below. I understand that such revocation will not affect disclosures/uses made or actions taken in reliance on this Authorization before the revocation was received. I understand that I may receive a copy of this Authorization after I have signed it, the original will be included in my health record, and I may inspect or receive copies of the information to be used or disclosed, as provided in 45 CFR 164.

_____ _____ _____

Signature of Client or Authorized Representative (AR) | Relationship to Client if signed by Representative | Date

**** A PHOTOCOPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL****

Send Requested Information/Revocation to: **CROSSROADS COUNSELING CENTER, INC.**

☐ The Harrisonburg Office, 250 E. Elizabeth Street, Suite 102, Harrisonburg, VA 22802	Phone: 540.801.0885	Fax No.: 540.801.8221
☐ The Luray Office, 221 W. Main Street, Luray VA 22835	Phone: 540.843.2509	Fax No.: 540.843.2512
☐ The Manassas Office, 7547 Presidential Lane, Manassas, VA 20109	Phone: 703.361.1525	Fax No.: 703.361.3395
☐ The Winchester Office, 174 Costello Drive, Winchester, VA 22602	Phone: 540.662.7007	Fax No.: 540.662.1311
☐ The Winchester OP Clinic, 420 W. Jubal Early Dr., #203, Winchester, VA 22601	Phone: 540.773.3193	Fax No.: 540.773.4982

Instructions for completing the Authorization for Use/Disclosure/Exchange of Protected Health Information

1. **Client Name** – Enter client's complete, given name. Do not use nicknames.
2. **Phone #**-Enter the client's complete phone number including area code.
3. **Date of Birth** – Enter client's **Date of Birth**.
4. **SSN or Medicaid #** - Enter the client's Medicaid Number (preferred, if applicable) or Social Security No.
5. **Name of Individual or Provider** - The personal name of the individual or provider to whom information may be acquired from, disclosed to or exchanged with. This field may be left blank if a personal name is not known or available.
6. **Company/Agency Name**: The company or agency name to whom information may be acquired from, disclosed to or exchanged with.
7. **Address and Phone or Fax Number** - enter the Name, City, State, Zip Code, and a Phone or Fax number. This information MUST be completed before the Client or Personal Representative signs the form. If unknown at the time of the intake, a separate release must be completed with any needed corrections or additions to the Authorization for Release of Information form.
8. **Information to be disclosed** – Check all that apply for the specific provider/agency. Other information needed that is not already listed must be specified in the **Other** section.
9. **Date of Service** – Enter the specific service Date or range of Dates of the documents being requested or dates of service for which information may be exchanged/shared with the designated provider/agency. **Every effort must be made to obtain and enter specific Dates of Service for the information being requested or exchanged.** Entering a Date range to include one previous year through the upcoming service year should be sufficient for most providers with whom information will be acquired from, disclosed to, and exchanged with during the period of service with CCC. If specific dates of service for past providers are unknown or not provided by the client, select **MOST RECENT ONLY** or **ANY** (whichever is most applicable).
10. **Use of information** – Check all that apply to disclose how the information will be used. If other uses are anticipated and not already listed, specify in the **Other** section.
11. **Authorization Effective**: Choose one option to define the effective date(s) or expiration date of this Authorization. An expiration date or event should be determined based on the individual/agency from whom or to whom information is being disclosed.
12. **Acknowledgement** – Please ensure that the client has fully read and understands the statements provided in the Acknowledgement section before signing. If an Authorized Representative is signing for the client, enter the appropriate information in **Relationship to Client** section. If the client refuses to sign the Authorization to allow disclosure/exchange of his/her PHI, indicate such on the Authorization form.
13. **Send To** - Select the appropriate **CCC Office** for the requested information or revocation to be sent.
14. Make a copy of the completed, signed Authorization form for the client, if requested. The original must be maintained in the client's file. No changes may be made to the Authorization form AFTER the client signs and is provided a copy. Updates or changes must be made on a new form with a new client signature.

Please note that **all sections** on this Authorization Form **must be completed** in order to be HIPAA compliant.