FAMILY LIVING INSTITUTE

1307 Jamestown Rd. Suite 202
Williamsburg VA, 23185

Phone: 757-229-7927
Fax: 757-253-8891

PERMISSION TO RELEASE INFORMATION

Client's Full Legal Name | Social Security Number | Date of Birth

Authorize:
- ☐ Dr. Syed Ahsan
- ☐ Dr.Alan H. Ali
- ☐ Jaskiran Singh
- ☐ Melvin Snead
- ☐ Brendina Tobias
- ☐ Elsa Beck
- ☐ Dr. Deborah Vick
- ☐ Dr. Sarah Bisconer
- ☐ Joelle Griffin Russell
- ☐ Jamie Ware-Jondreau

To ☐ disclose and/or ☐ receive from:

Name of Individual

Organization to which disclosure is made

Phone Number

Fax Number

Street Address | City, State | Zip Code

For the following treatment period of: One Year

- ☐ Intake Evaluation
- ☐ Discharge Summary
- ☐ Lab Results
- ☐ Medications Prescribed
- ☐ Progress Notes
- ☐ Psychological Testing
- ☐ All Confidential School Information (education eval., reports, and IEP)
- ☐ Psychiatric Consults/Notes
- ☐ Other (specify):

The Purpose for the disclosure of this information:

☐ Follow-up Medical Care ☐ Treatment planning/coordination of services ☐ My personal record/use

☐ Other:

As the person signing this consent, I understand that I am giving my permission to the above-named provider to disclose my confidential health care records that may include medical, psychiatric, HIV/AIDS and substance abuse information. I also understand that I have the right to revoke this consent at any time, except to the extent that action has been taken in reliance on It, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. I understand that the heath care entity may not condition treatment or payment on with my original heath records.

If not previously revoked this authorization will remain in effect unless revoked by the patient or guardian or until no longer reasonably necessary to accomplish the purpose for which it is given or specific date or event: _____ If there are No changes to the above information, this consent may be extended from the original date by re-signing the second line below.

Signature of Client or Guardian | *Date Signed* | *Witness* | *Date*

NOTICE TO THE RECIPENT OF THIS INFORMATIONS- REDISCLOURE PROHIBITION: This Information has been disclosed to you from records whose confidentially may be protected by the Federal law. Federal regulation (42 CFR Part 2) prohibits the receiving agency from making any further disclosure of this information without the specific written consent of the person to whom it pertains , or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to investigate or to prosecute any alcohol or drug abuse patient. If you give written consent to re-disclose your information by the recipient, it may no longer be protected by federal and state laws.

***Photocopies and Faxes of this form may be accepted in lieu of the original**