Avenues to Wellness

Walnut Avenue Associates, PC

Authorization for Release of Information

Client: __________________________ DOB: _______________ Case ID Number: __________________

I hereby authorize: Avenues to Wellness affiliated with Walnut Avenue Associates, PC___

Site Address: 16 Walnut Ave SW Roanoke VA 24016, Office 540-345-6468 Fax 540-345-3204

[Name and address(es) of physician, hospital, or health care provider]

to release/obtain/exchange my personal health and medical information as described below with the following person(s):

____

____

[*Name and address(es) of person(s) to receive/release/exchange information*]

For the following purpose(s): ☐ Coordination of Care ☐ Treatment Planning ☐ Payment purposes
☐ Emergency purposes ☐ At client request ☐ Other: ___________________________________

This information includes (check all that apply):

☐ Medical (Physical or Mental Health) Records ☐ Treatment Summary ☐ Discharge Summary
☐ Educational/Academic Records ☐ Behavioral Reports ☐ Treatment Plan
☐ Assessment/Clinical Evaluation ☐ Teacher Reports ☐ Progress Notes
☐ Psychiatric/Psychological Evaluation ☐ Neurological Evaluation ☐ Drug Screen Results
☐ Other (describe below): ☐ Court Report ☐ Substance Abuse Information

____

The information to be shared covers the following dates of service:

☐ All dates of service OR From (date or event) __________________ to (date or event) ____________

This authorization will expire on ______________________________ (fill in date or event), unless revoked by the undersigned.

This release, made freely and voluntarily, shall remain for the period noted above and may be revoked at any time with written notification executed by the responsible party noted below, except to the extent that action based on this consent has already been taken. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for treatment or benefits.

I understand that I may inspect or receive a copy of the information described on this form if I ask for it.

I understand that if the person or entity that receives the above information is not a health care provider or a health plan covered by federal privacy regulations, the released information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from redisclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A photocopy, fax, or electronically transmitted version of this document has the same force and effect as the original.

____ ______________________

Signature of client Date

____ ______________________________ ___________________

Signature of parent/guardian/client's representative Printed Name of Representative Date

If signed by other than client, indicate relationship: ____

If prepared and/or witnessed by a Avenues to Wellness Staff Member: __________________________________ (Staff member name)

Revocation of Authorization (if applicable):

Date and time written notice of revocation of authorization received: ____

Avewell Staff who received notice for file and notified Privacy Officer (print name): _________________________________