Family Service
of Roanoke Valley
Strengthen Families. Heal Trauma. Restore Hope.

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Client Name: SS# (optional):

Address: City: State: Zip:

Phone Number:

This Authorization will expire on the following date (90 days for 1 time release - not to exceed one year):

Please check one: ☐ I authorize access to my entire record.

☐ I authorize access only to my record from this date forward.

Purpose of Disclosure:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

[ ]Educational Evaluation [ ]Legal Status [ ]Medical Information [ ]Substance abuse [ ]Summary

[ ]Initial Interview [ ]Progress notes [ ]Tests [ ] Psychological Information

I acknowledge, and hereby authorize, Family Service to release information to or exchange information with:

I understand that:

1: I may refuse to sign this release and that signing it is strictly voluntary.
2: I may revoke this authorization at any time in writing, but not retroactive to data already released from prior consent.
3: I understand that by signing this release, Family Service will be in contact with the designated agency or person and provide/exchange information for the purpose written on this release.
4: I will receive a copy of this release after I have signed it. A copy will be placed in my case record.
5: No services will be denied if there is refusal to sign release.
6: Signing this document is voluntary and is not a requirement to receive services.

AUTHORIZATION TO RELEASE INFORMATION: As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Client's Signature: _____

Birth Date:: _____

Signature of Parent or Legal Guardian _____

Relationship to client: _____

FSRV Counselor: _____

Date: _____

Alliance for Strong Families and Communities

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www.fsrv.org

United Way