



**AUTHORIZATION FOR DISCLOSING AND/OR REQUESTING PROTECTED HEALTH INFORMATION**

Individual

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Individual Case Number: \_\_\_\_\_

**Henrico Area Mental Health and Developmental Services is hereby authorized to:**

- Request From
- Disclose To
- Request From and Disclose To

**Name of Treating Provider/Insurance Company/Other Entity:**

**ND/OR**

**Name of Individual:**

Relationship to individual served (optional):

Address: 3001 Hungary Spring Road, Suite A

City/State/Zip: Henrico, VA 23228

Phone: (804) 501-1670

Fax Number: (804) 501-2574

**Purpose of Request and/or Disclosure:**

**Legal Proceedings.** If this box is checked, no other purposes may be listed below. I agree to the use and disclosure of my substance use disorder treatment records and my other records as specified below to be used in the criminal, civil, legislative, or administrative proceeding identified below.

Case No. or Investigation No. (if known) and description of legal proceeding

- Assessment
- Coordination of care
- Payment for HAMHDS services
- Emergency contact
- Court-ordered evaluation
- At request of Individual
- Other, Specify: Report to Judge

**Description of Information to Request and/or Disclose:**

- Evaluation/Assessment
- Psychological Evaluation
- Medication(s) Prescribed
- Treatment
- General Physical Health
- Infectious Disease: AIDS, HIV, TB, Other
- Information related to an emergency
- Case Closing Summary
- Financial Information
- Photographs, videotapes, digital or other images
- Other, specify:
- Approximate service dates from \_\_\_\_\_ to \_\_\_\_\_

**Substance Use Information (disclosure must be limited to that information which is necessary to carry out the stated purpose):**

- This section does not apply to individual
- All of my substance use information created by HAMHDS
- All of my substance use information created by HAMHDS and all of my substance use information received from other treatment providers
- None of my substance use information

