**Medical Records Request**

The confidentiality and safety of your Danville-Pittsylvania Community Services (DPCS) records is very import to us. To request of a copy of your records please complete the release form below in its entirety, including signature and witness signature. Completed releases can be mailed, faxed, or emailed (see below). Most record requests are completed within 10 business days. Fees for the services may be charged. Please be sure to include a phone number on your release so Medical Records staff may follow up regarding fees or requested information. If you have any questions you may contact your direct provider or Medical Records at (434) 799-0456.

Please send completed release forms and a copy of picture ID to:

DPCS

Medical Records

245 Hairston Street

Danville VA 24540

Fax: (434) 791-2644

mrecords@dpcs.org

**DANVILLE-PITTSYLVANIA COMMUNITY SERVICES**

**245 HAIRSTON STREET**

**DANVILLE, VIRGINIA 24540**

**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

**Authorization for the Use and Disclosure of Individually Identifiable Health Information**

I understand that for all uses and disclosures, except those that do not require authorization or an opportunity to object, I must sign an individual authorization for such uses or disclosures.

I also understand that, if Danville-Pittsylvania Community Services is requesting the authorization for its own use, it will not condition the treatment, payment, and enrollment in a health plan, or eligibility for benefits, on my providing authorization for the requested use or disclosure.

**I understand that a copy of the signed authorization will be provided to me and that I may refuse to sign the authorization**. **I further understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by the privacy regulations.**

I understand that I have the right to revoke this authorization verbally and in writing by completing a revocation unless either of the following conditions exists:

* Danville-Pittsylvania Community Services has taken action in reliance thereon (including without limitation the provision of treatment services in reliance on a valid consent to disclose information to a third party-payer).
* This authorization was obtained as a condition of obtaining insurance and a law provides the insurer the right to contest a claim under the policy.

If I choose to revoke this authorization, I understand that I must deliver a written revocation to Danville-Pittsylvania Community Services at 245 Hairston Street, Danville, VA 24540.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Name of Individual)**

**Parent/Legal Guardian/**

**Authorized Representative Name** (PRINTED):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

authorize Danville-Pittsylvania Community Services to: 🞏 disclose to 🞏 receive from

 **Name and Address of Organization/Person (\* = REQUIRED)**

Organization/Name\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \*(if other than known local agency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

the following information:

🞏 Behavioral Health (Substance Abuse, Mental Health, and Prevention) 🞏 Developmental Services

🞏 Assessments 🞏 Treatment Plans 🞏 Progress Notes

🞏 Treatment Plan Reviews 🞏 Psychiatric Consultations 🞏 HIV/AIDS Diagnosis

🞏 Discharge Summary 🞏 Psychological Evaluations 🞏 Labs

🞏 Drug Screens 🞏 EKG

🞏 Entire Medical Record (includes Assessments, Discharge Summaries, medical Progress Notes, and Active Treatment Plan – If

 other info is desired, contact Medical Records (434)799-0456 x3054 to discuss the requested information and charge associated)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the following purpose(s): 🞏 at the request of the individual, 🞏 for coordination of services, 🞏 for financial/billing or 🞏 other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that:

* my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written authorization unless otherwise provided for in the laws and regulations.
* this authorization extends to information placed in my record after authorization was given, but before it expires.
* information may be shared in writing, verbally, and/or electronically.
* that this information may include Substance Abuse and/or HIV/AIDS information when applicable.
* the information to be released was fully explained to me and that this consent is given of my own free will.

Executed this, the \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20 \_\_\_\_\_\_\_\_

**I have been given a copy of this authorization\*:** 🞏 Yes 🞏 No (If no, explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_\_ date or, if unspecified, 365 days from the date it was signed by individual or representative.**

Signature of Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Authorized to Sign in Lieu of Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Include Title and Credentialing Documents)

Signature of Witness\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: Where information accompanies this disclosure form: this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. 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 criminally investigate or prosecute any alcohol or drug abuse patient except as authorized by a court order granted after application showing good cause. A copy of this form is as valid as the original.