APPLE TREE COUNSELING LLC

210 B Commerce St. Occoquan, VA 22125 Ph: (434) 299-8501

Authorization to Release/Exchange Confidential Information

All items 1-6 must be completed. An incomplete form is not a legally valid authorization. For multiple releases, multiple forms must be completed.

Patient Name: _____
Patient DOB: _____ Patient SSN#: __ __ __ - __ __ - __ __ __ __

I, the patient, or the responsible person for the patient, authorize the release of psychiatric and psychological information between the staff at Apple Tree Counseling, LLC (*210-B Commerce St, Occoquan Historic District, VA 22125 or 9300 Forest Point Cir. Manassas, VA 20110*) and the party listed as recipient, in accordance with the terms specified on this form.

1. **Recipient: _____ Phone: _____ Fax: _____**
   Address: _____

2. **Description of Information to be Disclosed (check any)**:

☐ **Assessment**	☐ **Educational Information**
☐ **Diagnosis**	☐ **Discharge/Transfer Summary**
☐ **Psychosocial Evaluation**	☐ **Continuing Care Plan**
☐ **Psychological Evaluation**	☐ **Progress in Treatment**
☐ **Psychiatric Evaluation**	☐ **Demographic Information**
☐ **Treatment Plan or Summary**	☐ **Psychotherapy Notes**
☐ **Current Treatment Update**	☐ **Emergency Information**
☐ **Medication Management Information**	☐ **Other**_____
☐ **Presence/Participation in Treatment**	☐ **Other**_____

3. Direction of Information Release (both checked for exchange)
   ☐ Sender to Recipient ☐ Recipient to Sender

4. Purpose:
   This information may be used or disclosed in connection with mental health treatment, emergency, payment, or healthcare operations. If the purpose is other than as specified above, please specify:
   _____
   _____

5. Mode Information is to be Disclosed (check any):
   ☐ Verbal ☐ Facsimile Transmission ☐ Snail Mail

6. Expiration of this Authorization (check one)
   ☐ One-time release ☐ One calendar year from today's date

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Revocation

I understand that if I wish to revoke this Authorization, I must do so in writing. Any releases of Information that occurred prior to this cannot be revoked.

By my signature, I attest that I am the patient identified above or that the patient is a minor less than 14 years and that I am the legal custodial parent or guardian of the patient; or that I am the legal or appointed guardian of the patient identified by the Court as legally incompetent. I understand the potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer protected by this sub-part.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent, Guardian, or Personal Representative Date

_____

Signature of Apple Tree Counseling, LLC Staff Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The federal law prohibits you from making further disclosure of this information unless expressly permitted, in writing, by the person or persons to which 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.