RIVER VALLEY COUNSELING, LLC

131 N. Ewing St., Unit B
Lancaster, OH 43130
740-689-6700
740-689-6702

AUTHORIZATION FOR RELEASE OR DISCLOSURE OF MEDICAL INFORMATION

Patient Name	**Release to / Release From**
Date of Birth	**Address**
Social Security #	**Phone**
	Fax

I hereby authorize River Valley Counseling, LLC, to examine and /or release a copy of medical records pertaining to Medical History, Mental or Physical Condition, Services Rendered, or Treatment (including but not limited to records of Drug and/or Alcohol Abuse or Psychiatric Treatment, HIV, Testing and/or AIDS /ARC Diagnosis and/or related condition, and STD testing and/or treatment.)

USE

_____Continuity of Care _____ Pursuant to legal action _____Insurance/Third party reimbursement

_____Other (Specify) _____

Information Requested

_____All Records _____Other (Describe) _____

Dates _____

Duration

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire 60 days after termination of treatment unless otherwise specified. If you request an exception, please write it here. _____

Restriction/Requirements

I understand that the information described above may be re-disclosed by the recipient if the information is kept as part of their records of treatment. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requiremants. In addition, any information received by River Valley Counseling, LLC, from another facility/physician by way of a signed authorization may be re-disclosed as part of our records of treatment unless otherwise specified.

I have been informed that certain situations may arise that requires my medical information to be faxed. This would include all types of information including drug/alcohol; psychotherapy notes or HIV related information dependent upon request.

Patient Signature/ Legal Guardian if Minor:

_____ **Date** _____

Witness:

_____ **Date**_____