Client Name:		Case #:		Date:	
SSN:		DOB:			

ARLINGTON COUNTY
AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Name of Third Party to Receive/Send Information:

Name: _____ Title: _____

Organization: _____

Address/Apt #: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Description of information to: ☐ Disclose/Send ☐ Receive ☐ Exchange (Disclose & Receive)

Format(s) of information: ☐ Written ☐ Spoken ☐ Electronic

Type(s) of information:
☐ Mental Health ☐ Substance Abuse
☐ Intellectual/Developmental Disabilities ☐ Medical/Physical

Assessments/Diagnostics:
- ☐ Diagnosis
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ HIV/AIDS/STD Diagnosis
- ☐ Psychosocial History
- ☐ Intake Summary
- ☐ Service Needs
- ☐ Financial Information

Treatment:
- ☐ Treatment Plan(s)
- ☐ Treatment Plan Reviews
- ☐ Progress Notes
- ☐ Status and Progress Reports
- ☐ Medication(s)
- ☐ Urinalysis Reports
- ☐ HIV/AIDS/STD Treatment
- ☐ Family Planning
- ☐ Benefits

Discharge:
- ☐ Discharge Summary
- ☐ Prognosis/Recommendations

Other:
- ☐ Educational Records
- ☐ Employment Records
- ☐ Criminal Justice Records
- ☐ Other:
- ☐ Other:

Purpose of disclosure:
- ☐ Coordination of treatment/services
- ☐ Verification of current or past treatment status
- ☐ Provision of evaluation and/or recommendation of treatment needs
- ☐ Eligibility determination
- ☐ Involvement of third party in treatment
- ☐ Other:

At request of individual or personal representative: ☐ Yes ☐ No

If no, explain:

Limited to a single disclosure: ☐ Yes ☐ No

If yes, explain:

If no, expires on: ☐ Date: _____

and/or ☐ Event: _____

I understand that my records are protected by Federal and/or State confidentiality laws and regulations and that they cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke this authorization at any time by written notification. Revocation will not apply to records already furnished in reliance upon this authorization.

(continued on page 2)

Client Name:		Case #:		Date:	
SSN:		DOB:			

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I acknowledge that the information to be released was explained to me and that this consent is given of my own free will.

Signature of Client or Person Authorizing Disclosure:

Name Date

Person authorizing disclosure is: ☐ Client ☐ Personal Representative ☐ Parent of Minor ☐ Guardian ☐ Power of Attorney ☐ In Loco Parentis

If other than client, name: _____

Signature of Staff Completing/Explaining Form:

Name Date

Signature of Witness, if Applicable:

Name Date

Arlington County Contact Information

Name:		Title:	
Division:			
Address:			
City/State/Zip:			
Phone:		Fax:	

This information may have been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules prohibit 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