Vine Psychiatric Associates *(VPA)*

14631 Lee Highway Suite 209, Centreville, VA 20121

Tel: 703-830-1800 * Fax: 703-830-1801 * Email: vinepsychiatric@gmail.com

Release of Information

Name:_____ DOB:_____ Last 4 Digit of SSN:_____

I authorize Vine Psychiatric Associates, LLC (VPA):
(check all that apply)

_____to receive the following protected health information form; or

_____to disclose the following protected health information to:
(Name and address and phone number of entity or class of persons to receive or disclose information)

The specific information to be released is as follows:

_____Psychiatric Records _____Psychological Records _____Psycho/Social History _____Treatment Plan _____Discharge Summary

_____Medical Records _____Educational Records _____Criminal Justice Records _____ Other:

This protected health information is being used or disclosed for the following purposes:

("At the request of the individual" if the request is made by the consumer who declines to state a specific purpose)

As this person signing the Release of Protected Health Information, I understand that I am giving permission for Vine Psychiatric Associates, LLC to release or obtain and use confidential health information. I understand that the information disclosed may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability (HIPPA) privacy regulations and may no longer be protected by state law and understand that a revocation is not effective to the extent that Vine Psychiatric Associates, LLC has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that may revoke this Consent/Authorization at any time, except to the extent that action has already been taken in reliance on it. I will notify the rendering provider n writing of my desire to revoke this Consent/Authorization; my revocation is not effective until delivered in writing to the person in possession of the client's medical records. **This Consent/Authorization will automatically expire upon termination of service by Vine Psychiatric Associates, LLC.**

_____ _____

Name of Client or Personal Representative Relation to Client

_____ _____

Signature of Client or Personal Representative Date

Please forward requested information or correspondence to the attention of:

Vine Psychiatric Associates, LLC

14631 Lee Highway, Suite 209, Centreville, VA 20121

Phone: 703-830-1800 / Fax: 703-830-1801

Note: This information may be protective by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.