



**TIDEWATER
PSYCHOTHERAPY
SERVICES**

Authorization to Disclose Protected Health Information

The undersigned authorizes

Tidewater Psychotherapy Services

260 Grayson Road, Suite 100, Virginia Beach, VA 23462

Phone: 757-497-3670 Fax: 757-499-1947

to release my health information as noted below:

Patient Information: Complete this area

Patient Full Name: _____ Date of Birth: _____
 Patient Address: _____ Other Names? _____
 City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To: Complete this area

Name/Facility: _____ Attention: _____
 Address: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: Personal Treatment Legal Insurance Transfer Other: _____

Information to be Released:

- General Outpatient Care Substance Abuse Treatment Psychological Testing
 Program Attendance/Compliance Medication List Drug Screen Results

Specify Date(s) of Service: _____

Entire Chart

Questions about your request or invoice can be answered by calling: BACTES Imaging at (877) 270-4365

If you fail to specify, 1 year of records will be provided.

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies. At no time will the cost-based fees exceed VA law (Statute: §8.01-413)

I understand I will be responsible for the charges incurred in the release of my protected health information.

**Rates are determined by Delivery Method Selected.
 *** PAYMENT OPTIONS: Check, Credit Card or Money Order**

DELIVERY METHOD	<input type="checkbox"/> Mail Records on CD	<input type="checkbox"/> Mail Records on Paper
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**A valid email must be provided above. If you do not select a delivery method, BACTES will determine the delivery method based on the information provided on this form. No charge for records being released to another healthcare provider.*

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (Please Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
 If I do not specify expiration this authorization will expire in 90 days.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.



Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*: _____ Date: _____

* For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.