AUTHORIZATION FOR DISCLOSURE OF PHI

To be completed by the health care provider

Patient name: _____ **ID Number:** _____
Date of Birth: _____ **Daytime Phone Number:** _____

Persons/organizations providing the information:

_____
_____
_____
_____

Persons/organizations receiving the information:

_____
_____
_____
_____

Specific description of information (including date(s)): _____
_____
_____
_____
_____

The information described above will be used or disclosed for the following purpose(s): _____
_____
_____
_____
_____

Expiration date: _____
To be completed if provider requests the disclosure for marketing purposes:
Circle as appropriate: TTN will receive / will not receive direct or indirect remuneration from a third party.

To be completed by the patient or personal representative

I hereby authorize the use or disclosure of my protected health information as described above.

I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment. I understand that the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.

I understand that if the organization authorized to receive the information is not a required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notification to: The Therapy Network, L.C., [762 Independence Blvd, Suite 772, Virginia Beach, VA 23455], Attention: Privacy Officer. Any revocation will not affect disclosures made prior to Practice's receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.

I certify that I have received a copy of this authorization.

_____
Signature of patient or patient's representative

_____
Date

Printed name of patient's representative: _____

Relationship to the patient: _____