Pediatric Associates of Alexandria

INOVA HEALTHPLEX
6355 WALKER LANE, STE. 401
ALEXANDRIA, VIRGINIA 22310

POTOMAC YARD
3600 S. GLEBE RD, STE. 150
ARLINGTON, VIRGINIA 22202

P. 703-924-2100 F. 703-922-6067
WWW.PEDSALEX.COM

Authorization for Behavioral Health Release of Information

Patient's Name: _____________________________ Date of Birth:____________________

Parent/Guardian Name: _____________________________

I authorize Pediatric Associates of Alexandria (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of therapy treatment, including, but not limited to therapist's diagnosis, of the patient listed above to:

Name of Individual or Organization____
Phone (______) - _______- ________ Fax (if applicable) (______) - _______- ________
Address ____
City _________________________ State ______ Zip ____________

The following information: (Patient or Guardian should initial each item to be disclosed)

___ Educational Records
___ Behavioral Reports
___ Diagnoses/Assessment
___ Progress Reports
___ Teacher Reports
___ Psychological/Psychiatric Evaluations
___ Medical Records/Medication Management Information
___ Treatment/Discharge Summary
___ Ongoing Verbal/Written Communication
Other: ____

1. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective.

2. I understand that this authorization will automatically expire after 1 year. Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form.

3. Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

4. I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

By signing this form, I certify:

- That I have read or had this form read/or had this form explained to me
- That I fully understand its contents
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction

Patient or Guardian Signature: ____________________________________

Date: ___________________