Sheltering Arms Institute
A collaboration with VCU Health

Authorization for Release of Protected Health Information

Patient's Name:	
Patient's SS #:	Patient's Date of Birth:

I request and authorize _____ to release information to:
(providing the information)

Name (receiving the information) _____

Address: _____

_____

Telephone #: _____ Fax #: _____

In the following format: ☐ written ☐ verbal ☐ audio ☐ video ☐ electronic ☐ other			
For the purpose of:	☐ Coordination of treatment and discharge planning; ☐ Coordinating the continuation of rehabilitative services; ☐ Assessing patient's ability to benefit from rehabilitative services; ☐ Development and implementation of treatment goals/rehab services; ☐ Requested by patient ☐ Other:		
Documentation to be released:	☐ Physician D/C Summary ☐ History & Physical ☐ Consult Report ☐ Physician Orders	☐ Physician Clinic Note ☐ Diagnostic Data ☐ Therapy Progress Notes	☐ Psychology Evaluation/Progress notes ☐ Mental health/substance abuse ☐ Other – specify below:
Dates of Treatment:			

- As the person signing this consent, I understand that I am giving my permission to use or disclose my confidential health records as indicated above
- I understand that this authorization is voluntary and that condition of treatment is not based on whether I provide authorization.
- I understand that if the organization authorized to receive the information is not a health care plan or provider, the released information may no longer be protected by law and redisclosure of that information may occur.
- I also understand that I have the right to revoke this authorization at any time, however revocation is not effective until delivered in writing to the person who is in possession of my records. Unless revoked sooner, this authorization will expire **one year** from the date of my signature.

Signature of Patient or Personal Representative:	Date:
Description of Personal Representative's Authority:	