RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

(Please check appropriate clinic and address)

☐	Fredericksburg Clinic, 600 Jackson Street, Fredericksburg, VA 22401 Phone: 540-373-3223 Fax: 540-371-3753
☐	Spotsylvania County Clinic, 7424 Brock Road, P. O. Box 277, Spotsylvania, VA 22553 Phone: 540-582-3980 Fax: 540-582-6825
☐	Stafford County Clinic, 15 Hope Road, Stafford, VA 22554 Phone: 540-659-2725 Fax: 540-659-0736
☐	Caroline County Clinic, 19254 Rogers Clark Blvd., Ruther Glen, VA 22546 Phone: 804-633-9997 Fax: 804-633-7031
☐	King George County Clinic, 8479 St. Anthony's Road, King George, VA 22485 Phone: 540-775-9879 Fax: 540-775-3887
☐	Parent Education - Infant Development, 700 Kenmore Avenue, Fredericksburg, VA 22401 Phone: 540-372-3561 Fax: 540-940-2286
☐	Rappahannock Adult Activities (RAAI), 750 Kings Highway, Fredericksburg, VA 22405 Phone: 540-373-7643 Fax: 540-373-2076
☐	Other:_____

I, _____ (SS#)_____ (DOB) _____
Full Name of Individual Receiving Services

authorize Rappahannock Area Community Services Board to: ❑ exchange with ❑ disclose to ❑ obtain from

_____
Organization and Name and Title

_____
Address

the following information: (Please be as specific as possible about dates, etc. on the lines provided by "Other")

☐	Social History	☐	Discharge/Treatment Summary dated:_____
☐	Medical Records	☐	Progress Notes dates of notes:_____
☐	Legal Status/ History	☐	Diagnostic Evaluation (please specify below)
☐	Emergency Contact	☐	Substance Abuse Information, including use and treatment history
☐	Infectious Disease information (ex. HIV, AIDS, TB)		
☐	Other (please describe)_____		

_____

for the following purpose(s) (Please be as specific as possible)_____

_____

in the following manner: (select all that apply) ❑ Written ❑ Verbal ❑ Video ❑ Photographs ❑ Electronic (email, fax)

❑ **I authorize RACSB to communicate with me via email. It is understood that the email system is unsecure and unencrypted and you are aware of the risks associated with this form of communication. Email is not a substitute for treatment purposes nor is it to be used for emergency situations. It is my responsibility to notify RACSB of email address changes. Your email address will be kept confidential and not shared or sold to a third party.**
Email Address: _____

I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires as described below.

Treatment, payment, enrollment or eligibility for benefits is not affected by signing this form.
I also understand that the information disclosed may be subject to redisclosure by the recipient and no longer protected by law.

Date, Event, and/or Condition upon which this consent will expire _____ (10 years for video and/or photographs)

A copy of this authorization will be placed in the individual's record.

_____
Signature of Individual Receiving Services Date

_____
Signature of Parent/Guardian or Person Authorized to Sign in Lieu of Individual Receiving Services Date

_____
Witness Date

Please return this information to:_____

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. REV 6/13