## RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Fredericksburg Clinic, 600 Jackson Stroet, Fredericksburg, VA 22401 Phone: 540-373-3223 Fax: 540-371-3733     Gardine County Clinic, 742 Brock Road, P.O. Box 277, Spotsykania, VA 22553 Phone: 540-582-3895     Stafford County Clinic, 1524 Roges Road, Stafford, VA 22564 Phone: 540-639-9778 at 504-653-7703     Parent Education - Infant Development, TOS Kemora P-Avenue, Fredericksburg, VA 22455 Phone: 540-373-7643 Fax: 540-975-9897     Fax: 540-373-2078     Orter:
Statford County Clinic, 15 Hope Road, Stafford, VA 22564 Phone: 564-6569-2725 Fax: 564-6569-7736         Grant County Clinic, 479 St. Anthony's Road, King George, VA 22465 Phone: 564-675-6387 Pax: 564-775-5887         Parant Education - Infant Development, 700 Kommors Avonue, Fredericksburg, VA 22405 Phone: 540-373-617 Fax: 564-073-637         Image: County Clinic, 474 St. Anthony's Road, King George, VA 22405 Phone: 540-373-6763 Fax: 540-373-2076         Other
Caroline County Clinic. 19:24 Rogers Clark Bivd, Ruther Glen, VA 22:46 Phone: 804-633-9937 Fax: 540-75-3887         Parent Education - Infant Development, 700 Kenmore Avenue, Fredericksburg, VA 22:405 Phone: 540-373-7634 Fax: 540-940-2286         Rappahanock Adult Activities (RAAI), 750 Kings Highway, Fredericksburg, VA 22:405 Phone: 540-373-7634 Fax: 540-940-2286         Other:
Imp George County Clinic, 8479 SL. Anthonys Road, King George, VA 22485 Phone: 540-775-3887         Parent Education - Infant Development, 700 Kenmore Norue, Fredericksburg, VA 22401 Phone: 540-373-6763 Fax: 540-9278         Rappahannock Adult Activities (RAAI), 750 Kings Highway, Fredericksburg, VA 22405 Phone: 540-373-6763 Fax: 540-373-2076         Other
Parent Education - Infant Development, 700 Kenmore Avenue, Fredericksburg, VA 22401 Phone: 540-372-3561 Fax: 540-3473-2076         Other:
Rappahannock Adult Activities (RAAI), 750 Kings Highway, Fredericksburg, VA 22405 Phone: 540-373-7643 Fax: 540-373-2076         Other:
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         he following information: (Please be as specific as possible about dates, etc. on the lines provided by "Other")
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         he following information: (Please be as specific as possible about dates, etc. on the lines provided by "Other")         Bocial History         Wedical Records         Legal Status/ History         Diagnostic Evaluation (please be as specific as possible about dates, etc. on the lines provided by "Other")         Interferency Contact         Diagnostic Evaluation (please specify below)         Emergency Contact         Other (please describe)         Other (please describe)         Other (splease be as specific as possible)         In the following manner: (select all that apply)       Written         Value are ware 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 will be kept confidential and not shared or sold to a third party.         Email Address:       Email Address:         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 It may revoke this consent at any time, except to the exacten thas otherwise provided for in the laws and regulations. I understan
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Organization and Name and Title         Address         he following information: (Please be as specific as possible about dates, etc. on the lines provided by "Other")         Bocial History       Discharge/Treatment Summary       dated:
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Signature of Individual Receiving Services Date
Signature of Individual Receiving Services Date
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 WHEEP INFORMATION ACCOMPANIES THIS DISCLOSURE FORM. This information has been disclosed to you from recerds
NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records
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 nformation unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise

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restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.