Authorization to Release Protected Health Information

Inova Comprehensive Addiction Treatment Services (CATS)
3300 Gallows Road, Falls Church, Virginia 22042
Central Access(703) 776-7777 Fax (703) 776-7799

Patient Full Name _____ Medical Record # _____

Street _____ City _____ State _____ Zip _____

Telephone Numbers: (home) _____ (cell) _____

Patient's Date of Birth _____ Dates of Service _____

I, _____ authorize Inova Comprehensive Addiction Treatment Services to release / disclose the following information to:

Name or Person or Entity to receive information _____ Relationship to Patient _____

Street _____ City _____ State _____ Zip _____

Telephone Number _____ Fax Number _____

Information to be released / disclosed:

- □ Admission to the program
- □ Assessment and Diagnosis (Axis 1-5)
- □ Compliance with treatment recommendations and referrals
- □ Results of drug screens and breathalyzer tests
- □ Progress towards accomplishing treatment plan goals and objectives
- □ Other _____
- □ Diagnostic lab work
- □ Program participation
- □ Financial documentation
- □ Treatment plan goals and objectives

For the purpose of:

- □ Service coordination
- □ Participation in family program
- □ Reports to probation officer or attorney
- □ Emergency Contact
- □ Completion of family interview
- □ Other _____

I understand that my records are protected under Federal confidentiality regulations (42 CFR Part 2). Any person or entity receiving my information will be informed that re-disclosure is not permitted without my consent or otherwise permitted by the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it. I understand that written notification is preferred, but not required to revoke this consent and should be forwarded to the address at the top of this form. I understand that in any event this consent automatically **expires 90 days from the date of signature**. This consent includes information placed in my record after the date of the signature below.

I understand that Inova Comprehensive Addiction Treatment Services (CATS) may not condition my treatment on my decision to sign this authorization.

Signature of Patient or Authorized Representative _____ Date **(Authorization expires 90 days after signature)** _____

Printed Name of Authorized Representative (as applicable) _____ Relationship to Patient _____

Addressograph