Albemarle Counseling Associates, PLLC
106 Caty Lane
Charlottesville, VA 22901
voice 434.978.3900 fax 434.978.3933

Client Name _____
SSN _____
DOB _____

This authorizes Albemarle Counseling Associates, PLLC :

To Disclose/ Receive	This Information	For This Purpose	To/From	Effective Date
☐ *DISCLOSE* ☐ *RECEIVE*	☐ *Assessment* ☐ *ISP & Notes/Reviews* ☐ *Substance Abuse* ☐ *HIV/Aids* ☐ *Other Infectious Disease* ☐ *Other…*	☐ *Evaluation* ☐ *Treatment* ☐ *Service Coordination* ☐ *Other…*		

* As the person signing this authorization, I acknowledge that I am giving my permission to Albemarle Counseling Associates to use or disclose confidential information which may include protected health information.

I further acknowledge that:

I may refuse to sign this authorization.

* Albemarle Counseling Associates may not condition the provision of treatment to me on my signing of this authorization. The original or copy of this authorization shall be included in my original records.

* I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records.

* There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule.

If this information is being disclosed from records protected by the Federal Substance Abuse Confidentiality Rules (42 CFR Part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my written authorization or as otherwise permitted by 42 CFR Part 2.

* A general authorization for the release of medical or other 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 client.

* **For court ordered treatment this release will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole or other proceeding under which I was mandated into treatment or:** _____.

* If not previously revoked, this authorization **WILL EXPIRE ONE (1) YEAR AFTER THE DATE OF MY LAST CLINICAL TREATMENT SESSION WITH JOHN PENN TURNER, LPC/LSATP.** This authorization ***DOES*** extend to information placed in my record after I signed this form.

_____
Signature of Client or Authorized Representative Date Relationship to Client (leave blank if client)

I, _____
(Name and title of person sending/obtaining the information)
am authorized to use or disclose the information that is subject of this authorization.