Davis Dynamics

Jana Davis, LCSW

317 Office Square Lane, Suite 202B Virginia Beach, VA 23462

Ph. 757-918-9874. Fax 757-821-1172. E: davisdynamicsworks@gmail.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, whose date of birth is _____authorize Jana Davis, LCSW to disclose to and/or obtain from:

(FULL NAME)

Name/Agency: _____

Address: _____

Phone: _____ Fax: _____

The following information (check all that apply):

( ) Psychiatric Evaluation ( ) Psychological Testing/Assessment

( ) MD Progress/Psychotherapy Notes ( ) Substance Abuse Treatment

( ) Oral Communication ( ) Billing/Insurance

( ) Scheduling ( ) Other (specify) _____

Purpose of Disclosure:

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, to coordinate treatment services.

Please specify if this disclosure is for other purposes: _____

Revocation:

I understand I have the right to revoke this authorization in writing at any time by sending written or verbal notification to Jana Davis, LCSW at 317 Office Square Lane, Suite 202B Virginia Beach, VA 23462. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance of the authorization. My decisions are not allowed by law to affect treatment, payment, or my eligibility for services. In consideration of these statements, I agree that this consent of release will expire on ___/___/_____.

Authorization and Signature:

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Client Signature:_____ Date:_____

There is a fee of $0.50 per page up to 50 pages and $0.25 a page thereafter and a $10.00 search, postage, and handling fee. As a courtesy, there will be no charge if records are requested by or sent to a physician or mental health professional. It can take up to 15 business days to process.