Exhale Behavioral Health
2913 Valley Avenue, Suite 125 Winchester, VA 22601
Phone: 540-692-9428 Fax: 540-750-4046
AUTHORIZATION FOR RELEASE OF INFORMATION

Print full name of person about whom information is being sought/released: _____
Exhale Behavioral Health is authorized to: _____Obtain from _____Disclose to
Name(s) and Title(s) _____
Name of Agency _____
Full Address _____
Phone _____ Fax _____

INITIAL each **item** for which you are authorizing disclosure:

_____1. Attendance Record	_____ 7. Financial Information
_____2. Social History	_____ 8. Diagnosis
_____3. Psychological Evaluation	_____ 9. Treatment/Service Plan
_____4. Medical Record	_____10. Alcohol/Drug Treatment Records
_____5. Medication Record	_____11. Progress Notes
_____6. Educational Assessment	_____12. Group Notes

***Select One** - This authorization ☐ **Includes** ☐ **Does not include** information placed in my record after signature date.
Limitations (if any) _____

Reason for Disclosure _____
As the person signing this authorization, I understand that I am giving my permission to the above named provider to obtain and/or disclose my confidential health care information and my signature is not a requirement for receiving services. I also understand that once the information is disclosed, Sharon Shavit, LLC is not responsible for redisclosure. A copy of this authorization will be given to me and the original will be included in the health care record. This authorization will expire (1) year from the date signed, or indicate a specific date, event or condition _____

_____

I understand that I have the right to revoke this authorization at any time, but that I cannot revoke information already released in accordance with the authorization. My revocation is not effective until delivered in writing to Exhale Behavioral Health

_____	_____	_____	_____
Date	Client's Full Signature	Last 4 digits of SSN	Date of Birth
_____	_____	_____	
Date	Parent, Legal Guardian or Legal Representative	Authority of Legal Rep	
_____	_____		
Date	Staff/Witness Signature		

NOTE: This information may be protected by federal regulations concerning alchohol and drug abuse patient records (42CFR, Subchapter A, Part 2), which prohibits a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by such regulations. These regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Date of Revocation: _____