MICHAEL N. GARCIA, L.P.C.

205 EAST HIGH ST CHARLOTTESVILLE VA 22902

AUTHORIZATION TO EXCHANGE INFORMATION

Patient's Name_____

Telephone_____Date of Birth_____

SS#_____

Permanent Address_____

I understand that this authorization is voluntary. I understand that private health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that records may contain information regarding mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information. I further understand that by signing below, I am authorizing the exchange of the above named patient's private information between the clinician and the parties named below. I understand that I may revoke this authorization at any time by notifying the clinician in writing. Parties authorized to exchange information:

1. Name_____Telephone_____

Relationship to patient_____

Address_____Initials_____

2. Name_____Telephone_____

Relationship to patient_____

Address_____Initials_____

Check appropriate type(s) of information to be exchanged: ___All ___Treatment plan(s) ___Diagnoses ___Psychiatric/ psychological evaluations ___Educational evaluations ___Physical evaluations ___Medication ___Claims/Eligibility/Benefits ___Progress reports ___Attendance ___Other

The purpose of this release is: ___Continuity of treatment ___Benefit management ___Administration of Worker's Compensation claim ___Employer Mandated Treatment Referral ___Subpoena or other legal process ___Other

I authorize the above exchange of pertinent private health information between Michael Garcia, L.P.C. and the above named parties. This authorization is valid until_____.

Patient/ Parent/ Legal Guardian Date

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EFFECTIVE 11 January 2016