THE HUGHES CENTER
1601 FRANKLIN TURNPIKE DANVILLE, VA 24540
PHONE: (434)836-8500
FAX: (434)836-8552

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Resident Name) (Date of Birth) (Date of Admission)

I hereby freely and voluntarily authorize The Hughes Center to:
_____ **Release/disclose records of my health information to:**
_____ **Obtain records of my health information from:**

(Individual, Facility, Organization) (Telephone Number)

(Address) (Fax Number)

(City, State, Zip)

The purpose for this disclosure is:
- ☐ To assist in funding
- ☐ To assist in treatment planning
- ☐ To keep the above informed of resident's progress
- ☐ To assist in educational placement
- ☐ To coordinate discharge planning/placement
- ☐ Other (specify) _____

The information to be released/obtained includes:
- ☐ Discharge Summary
- ☐ Lab, X-Rays, EEG, EKG
- ☐ Psychological Testing
- ☐ Treatment Plans
- ☐ History and Physical
- ☐ Immunization Record
- ☐ Psychiatric Evaluation
- ☐ Verbal exchange of information
- ☐ Substance Abuse Treatment
- ☐ Educational Assessments/Testing/Evaluations and Records
- ☐ Other_____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential heath care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not rediscover them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

This consent expires on (date):_____

NOT REQUIRED _____ _____
Resident Signature *(Signature required if alcohol or drug treatment is involved)* Date

_____ _____
Parent/Guardian/If Authorized Representative (Describe: _____) Date

_____ _____
Witness Signature Date

* Drug/Alcohol records are protected by Federal confidentiality rules (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse resident.