Cloud Break Therapy

AUTHORIZATION TO RELEASE INFORMATION

I, **(name of patient)**____________________________, (hereinafter "Patient") hereby authorize ____ (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

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I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 101 South Whiting Street, Suite 318, Alexandria, VA 22304 to be effective. This disclosure of information and records authorized by Patient is required for the following purpose:

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The specific uses and limitations of the types of medical information to be discussed are as follows:

___ Discharge Summary	___Court/Agency Documents	___Psychosocial Report
___ Psychological Tests Results	___Treatment Plans	___Consultation Records
___ Chemical Use History	___Progress Notes	___Family/Systems Evaluations
___ Diagnoses	___Crisis Intervention Reports	___Attendance Records
___ Mental Status Reports	___Therapist Orders	___Services

Other: (specify) __________________________ __________________________________

Such disclosure shall be limited to the following specific types of information:

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Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Virginia law may protect such information.

This authorization shall remain valid until: ____________________________________

Patient's signature:____________________________________Date:_______________