HIPAA COMPLIANT HEALTH INFORMATION RELEASE AUTHORIZATION

In accordance with Virginia Code Sections 8.01-413 and 32.1-127:03

Patient Name	*Date of Birth*	*Social Security Number*
Patient Address		

1. SCOPE OF AUTHORIZATION: You are hereby authorized to furnish and release to Anna Clarke Sas, Esquire, my Personal Health Information.

- I hereby specifically authorize release of all records regarding mental health treatment, alcohol and drug abuse, psychotherapy notes, and/or confidential HIV records. _____ (initials)

2. PURPOSE/REDISCLOSURE: The purpose of this disclosure is to allow Anna Clarke Sas, Guardian ad litem for a minor child/children to investigate my health, mental health, drug or alcohol abuse in relation to a pending custody/visitation matter pursuant to Virginia Code § 20-124.3 and §16.1-266. The disclosed Personal Health Information may be re-disclosed by Ms. Sas to the Court in her sole discretion and as she sees fit. I understand that this further disclosure by Ms. Sas may act as a forfeiture of my right to privacy concerning this information.

3. COPY AS VALID AS ORIGINAL: I ask that you accept a copy of this Personal Health Information Release Authorization as having the same validity, force and effect as an original.

4. EXPIRATION: This authorization shall remain in effect for five years. Upon the expiration of those five years, this Authorization shall terminate.

5. REVOCATION/EXPIRATION: I understand that I may revoke or limit the scope of this authorization by notifying Ms. Sas in writing of my desire to so revoke or limit. Furthermore, I do so revoke all authorizations given by me prior to the signing of this authorization.

Name and address of health provider or entity to release this information:

NAME OF REQUESTOR: Anna Clarke Sas, Esquire, Guardian *ad litem*
Virginia Beach Law Group
780 Lynnhaven Parkway, Suite 220
Virginia Beach, Virginia 23452

Specific information to be released:

☐ Medical record from _____ (dates of service)
☐ Entire medical record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers
☐ Other: _____

☐ Include (indicate by initialing)
☐ Alcohol/drug treatment
☐ Mental health information
☐ HIV-related information

Authorization to Discuss Health Information

☐ By initialing here _____, I authorize _____ to discuss my health information with Anna Clarke Sas, Esquire, Guardian *ad litem*.

_____ _____
☐ Patient Date
☐ Patient's Legal Guardian (Relationship _____)
☐ Patient's Representative (See Attached Power of Attorney)