

GENERAL CONSENT TO DISCLOSE INFORMATION

I, _____ authorize:
[Print Full Name of Person(s) Consenting to Disclosure or Authorizing Release of Protected Health Information]

YES Behavioral Health, Inc. (YES), and/or its affiliated companies (i.e., Life Changers Mental Health & Supportive Services of VA, Life Coach Community Services of VA, Youth Residential Services of VA, and The Wellness Center of Central VA, Inc.)

- | | |
|---|--|
| <input type="checkbox"/> To disclose to | <input type="checkbox"/> client's school |
| <input type="checkbox"/> Exchange with | <input type="checkbox"/> family members |
| <input type="checkbox"/> Obtain from | <input type="checkbox"/> health care providers |
| | <input type="checkbox"/> state/local government agencies |
| | <input type="checkbox"/> Other _____ |

The information specified below concerning the treatment of:

(Print Client's Full Name)

Information that may be disclosed: all of the following **or** *[check all that apply]*:

- | | | |
|---|--|--|
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Employment |
| <input type="checkbox"/> Services Received | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> History/Performance |
| <input type="checkbox"/> Medication(s) Prescribed | <input type="checkbox"/> Social History | <input type="checkbox"/> Urine Drug Screen Results |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Substance Abuse/Use History | <input type="checkbox"/> School Results |
| <input type="checkbox"/> Evaluation/Assessment | <input type="checkbox"/> Family/Social History | <input type="checkbox"/> Case Closing Summary |
| | <input type="checkbox"/> Legal Status/History | <input type="checkbox"/> Other |

Information should be sent to the following address:

Attention: _____
P.O. Box 74100
Richmond, VA 23236

Or fax to: _____

As the person signing this Consent to Disclosure and Authorization for the Release of Protected health Information, I understand that I am giving permission for YES to release or obtain and use confidential health information. I understand that treatment, payment, enrollment or eligibility for benefits is not affected by signing this form. I understand that I may refuse to sign this Authorization. I also understand that the information disclosed may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations and may no longer be protected by state law. A copy of this Authorization will be included in the client's service (medical) record.

I understand that I may revoke this Consent/Authorization at any time, except to the extent that action has already been taken in reliance on it. I will notify YES in writing of my desire to revoke this Consent/Authorization; my revocation is not effective until delivered in writing to the person in possession of the client's medical records. This Consent/Authorization will automatically expire upon termination of service in the Agency.

[Client's /Legal Authorized Representative's Signature] **

[Date]

****Authorization must be signed by the Client.** If the signature is not that of the Client, check one of the following:

- Client is a Minor Client is unable to sign for the following reasons(s): _____