



S E N T A R A™

Sentara Behavioral Health Services  
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## Authorization to Release Protected Health Information Form

Member's Name: \_\_\_\_\_  
Member ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Consent is Valid for **30 days** unless noted otherwise:  
Consent valid for \_\_\_\_\_ days

I hereby authorize \_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State, Zip Phone #

To receive / release information contained in the medical record / member file of:

\_\_\_\_\_  
Print or Type: Name of Member / Patient Date of Birth  
\_\_\_\_\_  
Medical Record Identification Number Date(s) of Service

For the specific purpose of: \_\_\_\_\_

### Information Requested:

- |   |  |
|---|--|
| <input type="checkbox"/> Claim(s) Data (Member Profile) | <input type="checkbox"/> Lab or X-ray data                       |
| <input type="checkbox"/> Diagnostic Studies             | <input type="checkbox"/> Operative Report                        |
| <input type="checkbox"/> Discharge Summary              | <input type="checkbox"/> Progress / Clinical Record              |
| <input type="checkbox"/> History and Physical           | <input type="checkbox"/> Psychiatric & Psychological Information |
| <input type="checkbox"/> Complete Medical Record        |  |
| <input type="checkbox"/> Other (Specify):               |  |

State date, event, or expiration of authorization, if any: \_\_\_\_\_

I, the undersigned, understand that I may revoke this consent at any time. Also, upon fulfillment of the above stated purpose, I understand that my authorized representative or I may receive a copy of the release. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for a period of 30 days, unless otherwise noted above.

Signed \_\_\_\_\_ Witness \_\_\_\_\_  
Date \_\_\_\_\_ Date \_\_\_\_\_

Unless the above named person is over 13 years of age or an emancipated minor, in which case the minor has the ability to act on his / her own behalf, and may sign his / her own authorization; or if the above named person has a legally appointed guardian, the release must be signed by his / her parents or guardian. Proof of guardianship may be required in some cases.

Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_