VCU Center for Psychological Services and Development
epartment of Psychology | College of Humanities and Sciences
612 N Lombardy St | Box 843033 | Richmond, VA 23284-3033
804 828-8069 | F: 804 827-1269 | cpsd@vcu.edu | www.cpsd.vcu.edu

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Client Name: ____ DOB: ________________

Guardian/Authorized Representative (if other than client): ____________________________________

Relationship to Client: ____

I hereby authorize the release of information:

To / From: VCU Center for Psychological Services and Development
612 N. Lombardy St Box 843033
Richmond, VA 23284-3033

To / From: Name: ____

Address: ____

Phone: ________________________________ Fax: ______________________

Information to Disclose:

☐ Complete Medical/Mental Health Records
☐ Treatment Plans / Progress Notes
☐ Assessment Report
☐ Documentation of Attendance
☐ Intake / Termination Summaries
☐ Other: ________________________________

Purpose for This Disclosure:
☐ Coordination of Care ☐ Insurance ☐ Treatment Planning ☐ Other: ________________________________

Method of Disclosure: ☐ Verbal ☐ Written

Method of Delivery: (when requesting records for myself)

☐ Secure email to:____________________________________ ☐ Mail paper copies (to address above)

☐ Pick up paper copies (enter name if different than client): ________________________________

Authorization Expires:
☐ When no longer receiving services at CPSD ☐ One year from date signed ☐ Other:__________________

As the person signing this authorization, I understand that:

- I am authorizing the Center for Psychological Services and Development (CPSD) to disclose my confidential health records. CPSD shall maintain a copy of this authorization in my health records.
- The CPSD will not condition treatment on whether or not I sign this authorization.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken upon it. My revocation will not be effective until delivered in writing to the CPSD. A copy of my revocation shall be maintained.
- I understand that health information disclosed pursuant to this authorization might be re-disclosed by the recipient and, in such case, may no longer be protected to the extent as when solely in the possession of the CPSD.
- A photocopy/fax of this authorization will be treated in the same way as an original.

____ ______________________

Client or Parent/Guardian/Representative Signature Date

UNDERSTANDING YOUR RIGHTS PERTAINING TO YOUR RECORDS (FOR USE AND DISCLOSURE)

FACTS ABOUT OBTAINING YOUR MEDICAL RECORDS

You have the right of access to inspect and obtain a copy of your confidential health care information.

By law, a signed authorization form which contains the criteria included on this other side of this form is required to release medical records. The form must be fully completed before any information can be released.

CPSD provides a designated record set (DRS) for your selection of ‘Complete Medical/Mental Health Records’ in the form. The DRS contains your medical and billing records that we physically/electronically store and maintain and only includes those portions of medical records that are used to make decisions about your mental health care.

We are not able to provide: (A) items not maintained in legal health records, (B) education records that are exempt, (C) psychotherapy process notes, or (D) raw test data summarized in the medical record. We may legally deny your request for access to your medical records, with the opportunity for appeal, if access is reasonably likely to endanger your life or the life of another person or to cause substantial harm to you or to another person.

COST

The minimum processing fee for one copy of your DRS is $5.00. If you request paper copies and your DRS exceeds 50 pages, you will be charged the minimum fee plus 25₵ per page for each page over 50.

CPSD will deliver one copy of your DRS to the medical or mental health provider listed on the form at no charge.

HOW DO I REQUEST MY RECORDS FOR MYSELF?

Complete the “Authorization to Release or Obtain Information” form in its entirety. Enter your name and address in ‘To/From’ and select ‘Complete Medical/Mental Health Records.’ By default CPSD will hold your records for pick-up. If you prefer, select a different delivery method on the form.

Individuals picking up records must present valid government issued I.D.

Your request will be completed within 15 business days of our receipt of the request. You will be notified when your records are ready or if the records cannot be processed within 15 business days.

HOW DO I RELEASE MY MEDICAL RECORD TO OTHERS?

Complete the “Authorization to Release or Obtain Information” form in its entirety. The form may be hand-delivered, mailed or faxed to:

VCU Center for Psychological Services and Development
612 N Lombardy St, Box 843033
Richmond, VA 23284-3033
fax: 804 827-1269

CPSD will release your records within 15 business days of our receipt of the request. Your records will be delivered by secure file transfer, or by fax if secure file transfer is unavailable, to the name and address on the form.