Emmaus Family Counseling Center

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Full Legal Name: _____

Date of Birth: _____

Street Address on File: _____

Phone Number on File: _____

Email Address on File: _____

Last Four Digits of Social Security Number: _____

1. Consent for Emmaus to Transfer Records

This authorization is issued in connection with the closure of EMMAUS FAMILY COUNSELING CENTER, LLC ("the Practice"). I authorize the Practice, located at 20925 Professional Plz Ste 320, Ashburn, Virginia 20147, email chris.cole@efccva.com, phone (703) 729-2822, to disclose and transfer my complete health record and all related Protected Health Information (PHI) to the recipient(s) identified in Section 2.

The purpose of this disclosure is to facilitate any of the following: assessment, treatment or coordination of care, insurance or payment matters, or any other purpose you specify. If you wish to limit the purpose of this disclosure, please indicate any restrictions here: _____.

Once my complete health record has been transferred to the provider or recipient named below, the Practice may discontinue maintaining my records as permitted under Virginia Code §§ 54.1-2405 and 32.1-127.1:03. The Practice may destroy records after transfer or after the expiration of the applicable statutory retention period. I understand that I may request a personal copy of my records before destruction or before the Practice ceases maintaining them.

Note: the Practice will be permanently closing. For more information, please see www.efccva.com or email Chris Cole at chris.cole@efccva.com.

2. Recipient of Records

To ensure continuity of care, I authorize the Practice to transfer my full and complete health record, including all PHI, to the person(s) or organization(s) below.

Recipient #1

Name: Redeeming the Time, Inc. /Redeeming the Time Family Counseling Services
Address: PO Box 175
City: Purcellville State: VA Zip: 20132
Phone: 540.592.1782 Fax: n/a

Recipient #2 (optional)

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

3. Description of Information to Be Disclosed

I authorize the complete transfer of my entire health record, including but not limited to: medical records, treatment summaries, psychological and mental health records, school or collateral records, progress notes, verbal communications, diagnostic materials, administrative or billing records, and any other information maintained by the Practice. The Practice will disclose my health record, consistent with this authorization, within thirty (30) days from the date that the Practice receives this authorization.

Format of Records Provided

Unless I indicate otherwise below, the Practice will provide my records in both physical and electronic formats, to the extent each format is reasonably available.

☐ Physical copies only

☐ Electronic copies only

Substance Use Disorder Treatment Records

Some or all of the information disclosed under this authorization may be protected by the federal confidentiality rules found at 42 C.F.R. Part 2, which apply to substance use disorder treatment records. If so, these records may not be redisclosed by the recipient without my express written permission, unless such redisclosure is specifically allowed by federal law. Unauthorized redisclosure is prohibited and may result in penalties.

4. Expiration, Right to Revoke, and Record Maintenance After Transfer

This authorization expires one (1) year from the date of signature unless revoked earlier in writing. Revocation is not effective for records already released.

Record Maintenance Acknowledgment (Required for Practice Closure)

By signing below, I acknowledge:

- Once my record is fully transferred, the Practice may discontinue maintaining my records as permitted under Virginia law (§§ 54.1-2405 and 32.1-127.1:03).
- The Practice may destroy records after transfer or after required retention periods.
- I may request a personal copy before records are destroyed or maintenance ceases.
- I have been informed that I may request a personal copy of my health record.

Further by signing below, I acknowledge:

- As of the date of this application, the Practice has complied with required Virginia retention laws (minimum 6 years; longer for minors and certain federal obligations).

- The Practice will maintain my record only until (a) confirmation of successful transfer or (b) expiration of the legal retention period.
- I release the Practice from further record-maintenance obligations once these conditions are met.

5. Withholding of Records Under Virginia Law (§ 32.1-127.1:03(F))

Under Virginia law, the Practice may decline to furnish certain records if a treating physician, clinical psychologist, clinical social worker, or licensed professional counselor determines in writing that disclosure would (1) be reasonably likely to endanger my life or physical safety, or (2) cause substantial harm to another individual referenced in the record. If access is denied for these reasons, I understand that I may designate—at my own expense—another qualified reviewing professional with equivalent training and experience to determine whether the records should be released

6. Verification of Identity and Authority

Virginia law requires the Practice to verify the identity of the person making this request. If the identifying information you provide above matches the information already contained in your health record, the Practice will consider that sufficient verification. If the information does not match our records, or if the request is being made on behalf of someone else, then the Practice will require one of the following forms of documentation:

A. Evidence of Identity (attach or present one):

☐ Government-issued photo ID

☐ Other valid ID: _____

B. Evidence of Authority (if requester is not the patient):

☐ Medical Power of Attorney / Advance Directive

☐ Court Order (guardianship, conservatorship)

☐ Legal authority as parent of a minor (unless exceptions apply)

☐ Executor/Administrator of estate

☐ Other lawful authorization: _____

The Practice may decline release if your identity or authority cannot be verified.

7. HIPAA, Federal, and Virginia Patient Rights Disclosures

I understand:

- My treatment, payment, or eligibility for benefits cannot be conditioned on signing this authorization, except as allowed by law.
- Once released, records may be redisclosed and lose certain HIPAA protections, except for specially protected categories (mental health, substance use, HIV/AIDS, etc.).

- Health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the Practice.
- I may review or obtain copies of my records.
- I may request a copy of this authorization.
- I may revoke this authorization at any time by submitting a written request by email to Chris Cole at chris.cole@efccva.com. My revocation will not affect any disclosures that the Practice has already made in reliance on this authorization and will become effective only when received by the Practice.
- Disclosures will be documented in my original record.
- Nothing in this authorization is intended to conflict with applicable law. All relevant legal requirements are incorporated into this authorization, including any rights reserved by the Practice under those laws.

8. <u>Signatures</u>

Client/Patient: _____ Date: _____

Parent/Legal Representative (if applicable):

Name: _____

Authority/Relationship: _____

Signature: _____ **Date:** _____