Wayne K. Pansa, Jr., LCSW, LLC

5205 W. Woodmill Dr., Ste. 33LL, Wilmington, DE 19808

302-455-7065

Authorization for Release of Records Form

☐ I authorize Wayne K. Pansa Jr., LCSW, LLC to **send** my records

☐ I authorize Wayne K. Pansa Jr., LCSW, LLC to **receive** my records

This form, when completed and signed by you, authorizes Wayne K. Pansa, LCSW, LLC to receive and/or release information from your clinical record.

I, _____ authorize Wayne K. Pansa Jr., LCSW, LLC to release and/or obtain the following information noted regarding my medical, medical, and mental health and substance abuse records for myself DOB: _____
or my minor child: _____ DOB: _____

Information can be released to/received from the following:

Name: _____
Street Address: _____
City, State, Zip: _____
Phone number: _____ Fax: _____

Information I want to be released: _____

Records or information from: _____ to _____
Beginning date End date

For the purpose of: ☐ Continuity of Care ☐ Background Information ☐ Evaluation
☐ At the request of individual ☐ Other _____

This Authorization is valid until you are discharged from this incident of care or until retracted in writing. You have the right to revoke this Authorization, in writing, at any time by sending such written notification to the office address listed below. The revocation will take effect when Wayne K. Pansa, LCSW, LLC receives and processes the letter. I understand the letter will not have any effect on the uses/disclosures of my health information that were made before Wayne K. Pansa Jr., LCSW, LLC processed my letter. A revocation may not be effective if this Authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Wayne K. Pansa Jr., LCSW LLC generally may not condition behavioral health services upon my signing an authorization unless the services are (i) research-related; or (ii) provided to me for the purpose of creating health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of my information and no longer protected by federal privacy regulations. However, any disclosure of information that pertains to the treatment or diagnosis of drug abuse or alcohol abuse or a referral for such treatment or diagnosis, and which would identify a patient as an alcohol or drug abuser, permitted hereunder shall be accompanied by the following written statement: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Any facsimile, copy, or photocopy of this Authorization shall have the same effect as the original.

Patient's signature (if over 18): _____

Printed Name: _____

Parent/Guardian's signature (if patient under 18): _____

Parent/Guardian's printed name: _____

Date:

**If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.