My Psychiatrist, PLC

PHONE: (703) 596-4796
FAX: (703) 787-8210

CERTIFIED

CONSENT TO RELEASE

PSYCHIATRIC/ MEDICAL and/or ALCOHOL/DRUG ABUSE RECORDS

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Virginia law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information. This consent can be removed at any time with written request from the patient. If not previously revoked, this consent will terminate by the end of 2 years from today's sign date.

Patient Full Name: _____Date of Birth: _____

☐ **Obtain Information From** **OR** ☐ **Release Information To**

Name: _____ Date: _____

Phone: (_____) _____Fax: (_____) _____

Information to be disclosed (please check one):

☐Complete medical Record

☐Verbal Communication between Providers

☐Other……

Records from (insert date) _____ to (insert date) _____

OR

Please disclose my information to

_____ Relationship:_____

_____ Relationship:_____

_____ Relationship:_____

Reason for release of information (*Choose all that Apply):*

☐ Treatment/Continuing Medical Care ☐Personal Use ☐Billing or Claims ☐ Insurance ☐ Legal Purposes

☐ Disability Determination ☐School ☐Employment ☐ Other *(Specify)*: _____

_____ _____

Patient/ legal guardian Name Patient/ Legal guardian authorizing signature

My Psychiatrist health care provider authorizing to disclose this information:

Clinician Name: _____ Date: _____

Clinician Signature: _____