

**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: \_\_\_\_\_