RIVERPOINT PSYCHIATRIC ASSOCIATES
155 Kingsley Lane, Suite 320
Norfolk, Va. 23505
Phone (757) 489-4700 Fax (757) 489-0240

PERMISSION TO RELEASE INFORMATION

Patient name: _____ Birth date: _____
Address: _____ SSN: _____
_____ Phone number: _____

Sending/Receiving person or agency: _____
Address: _____
City, State: _____ Zip code: _____ Phone: _____ Fax: _____

I request and authorize the release of the health care information described below:
__ TO Riverpoint Psychiatric Associates FROM the above person/agency
__ FROM Riverpoint Psychiatric Associates TO the above.

I specifically authorize the disclosure and/or use of:

__ Emergency room/Urgent care records	_ Consultation report	__ Admission note
__ Hospital records (nursing & progress notes)	__ Discharge summary	__ Lab reports
__ Medication history	__ Clinical summary	__ Letters
__ Outpatient progress notes	__ Initial psych. eval.	__ Psych. test. report
__ Substance abuse info.		
__ Telephone discussion	__ Other _____	

The requested records or information is about health care provided during the following approximate time frame: _____
Purpose(s) of disclosure: ___ At request of the individual
___ Other: _____
Authorization expires one year from date of signature on this form.
I understand that, unless action has already been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Riverpoint Psychiatric Associates.
I understand that Riverpoint Psychiatric Associates may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.
I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations.

Signature (patient or authorized representative): _____
Date: _____
Relationship/authority (if signed by authorized representative): _____
Witnessed at Riverpoint Psychiatric Associates by: _____
For (Provider's name):

___ Burt Segal, LCSW	___ Huma Hyder, MD
___ Raleigh Phillips, Psy.D.	___ Jennifer Cooke, PA-C
___ Karen Hazen, PhD, LPC	___ Timothy Taylor, LCSW
___ Anne C. Abraham, LCSW	___ Paul Callis, PA
___ Angel Williams-Kent, FNP-C	