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 number: _____ Fax number: _____

I request & 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
__ Hospital records (nursing & progress notes)
__ Medication history
__ Outpatient progress notes
__ Consultation report
__ Lab reports
__ Substance abuse info.
__ Educational testing
__ Other: _____
__ Admission note
__ Discharge summary
__ Clinical summary
__ Initial psychiatric evaluation
__ Psychological Test Rept.
__ X-Ray reports
__ Telephone discussion
__ Letters

The requested records or information is about health care provided during the following approximate time frame:
_____
Purpose(s) of disclosure/use: ___ 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) : __ Anne Abraham, LCSW
___ Timothy Taylor, LCSW
___ Paul Callis, PA-C
___ Raleigh Phillips, Psy.D.
___ Burt Segal, LCSW
___ Huma Hyder, MD
___ Jennifer Cooke, PA-C