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
___ Timothy Taylor, LCSW ___ Angel Williams-Kent, FNP-C
___ Anne C. Abraham, LCSW ___ Paul Callis, PA