SHENANDOAH PSYCHIATRIC MEDICINE

19 BRIAR KNOLL CT. SUITE 1 **PHONE (540) 949 0955**
FISHERSVILLE, VA. 22939 **FAX (540) 949 8377**

RELEASE OF INFORMATION

I authorize **SHENANDOAH PSYCHIATRIC MEDICINE** to share verbal and/or written evaluation and progress notes with:
*(Write in **name(s)** to share or '**NONE**' or you may decline and write '**NO**')*

(1) My Primary Care Physician (PCP): _____

(2) My Counselor: _____

(3) Insurance Company/Managed Care Company: _____

(4) I authorize **SHENANDOAH PSYCHIATRIC MEDICINE** to request and receive from the Virginia Department of Health Professions any and all records held by the Department relating to Schedule II-V controlled substances dispensed to patient named below.
(5) Other: _____

(6) I authorize **SHENANDOAH PSYCHIATRIC MEDICINE** to perform random drug screens for the purpose treatment planning.

This release **begins today** and **expires one (1) year** from my last **SHENANDOAH PSYCHIATRIC MEDICINE** appointment. It only applies to **OUTPATIEN**T behavioral information. Any information furnished is intended for **insurance authorization, treatment planning, and follow-up;** and recipient is prohibited from disclosing the information to any other party, except as allowed or required by law or regulation. Therefore, information released by us may be subject to re-disclosure and might no longer be protected.

I understand that I may revoke this **RELEASE** at any time before it expires by providing a written statement to **SHENANDOAH PSYCHIATRIC MEDICINE** Attn: Practice Manager**.**

I understand that my failure to sign this **RELEASE** may delay or otherwise impair my treatment.

A photocopy of this **RELEASE** has the same authorization as the original.

_____ _____
Patient Signature *Date*

_____ _____ _____
Parent/Guardian Signature (When needed) *Relationship* *Date*

_____ _____
Witness Signature *Date*

09/11/09