SHENANDOAH PSYCHIATRIC MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print Patient Full Name) Birth Date (MMDDYYYY)

_____ _____
(Street Address) Social Security Number

_____ _____
(City, State, Zip Code (Phone)

At the request of the Individual, I _____, do hereby authorize
(Patients Name)

SHENANDOAH PSYCHIATRIC MEDICINE
19 BRIAR KNOLL CT, SUITE 1
FISHERSVILLE, VA. 22939

___ To Release To: ____To Obtain From:

Name: _____

Street: _____

City, State, Zip Code: _____

DATES OF: _____

____DISCHARGE SUMMARY	____PATHOLOGY REPORTS	____EMERGENCY REPORTS
____HISTORY & PHYSICAL	____LABORATORY REPORTS	____ENTIRE RECORD
____PROGRESS NOTES	____RADIOLOGY REPORTS	____OTHER _____
____OPERATIVE NOTES	____EKG/EEG/CARDIAC CATH	____(PLEASE SPECIFY)_____

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

____REFERRAL TO SPECIALIST ____INSURANCE ____WORKERS COMP ____CHANGE OF DOCTOR
____LEGAL INVESTICTION ____PERSONAL ____CONTINUING CARE ____DISABILITY DETERMINATION
OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you: _____

If I have questions about disclosure of my health information, I can contact the Shenandoah Psychiatric Medicine office at 540-949-0955.
Upon request, I will be given a copy of this authorization form, after signing.

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification and that it will not affect any information, released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulation. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature if individual or guardian or Personal Representative of patient's estate Date

_____ _____
Signature of witness Date
Average turn-around-time is 10-15 days.

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