** River Road Psychiatry, LLC**

**10617 Patterson Avenue**

**Henrico, VA 23238**

**P: 804-250-9557**

**F:734-789-6521**

**Consent for Release of Confidential Health Information**

**Name: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize River Road Psychiatry, LLC to disclose to \_\_\_\_ and/or \_\_\_ obtain from:

**Name of Provider or Individual, including address, phone number and fax number**

**Description of Information to be disclosed/obtained:**

\_\_\_ Psychiatric Evaluation \_\_\_ Treatment Plan/Summary

\_\_\_ All Appointment Notes \_\_\_ Medication List

\_\_\_ Lab Work

\_\_\_ Visit Verification

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please specify)

**Purpose:**

This information may be disclosed or obtained in connection with my psychiatric treatment or coordination of overall healthcare. If the purpose is other than as specified above, please specify:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Revocation**

I understand that I have a right to revoke this authorization at any time by sending written notification to River Road Psychiatric, LLC by mail to 10617 Patterson Avenue, Henrico, VA 23238 or by fax to 734-789-6521.

**Expiration**

This release will expire one year from the date of authorization listed below unless otherwise

specified. If other than one year, please list requested expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that once the information is released pursuant to this authorization, River Road Psychiatry, LLC. providers have no control over what an authorized recipient may do with the information.

By signing below, I acknowledge I have read and understood the information above and understand the nature of this release and that I am giving my permission for the disclosure of confidential health care information. /

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date