Psychological Health-Roanoke
Colonnade One Corporate Center
2840 Electric Road, Suite 200
Roanoke, Virginia 24018
Phone (540) 772-5140 Fax (540) 772- 5158
For medical records, call 540-562-8766 or email (sstanley@psychhealthroanoke.com)

AUTHORIZATION TO RELEASE PROFESSIONAL INFORMATION

Patient Name: _____

Date of Birth: _____ Phone #: _____

Information to be exchanged between**:** **Psychological Health- Roanoke** and**:**

Name/Agency _____

Street Address _____

City, State, Zip Code _____

Phone Number: _____ **Fax Number**: _____

☐ **PCP** ☐ **Psychiatrist** ☐ **Other**: _____

Purpose of Release:
☐Continuity of Care ☐Communication ☐Legal Representation
☐Other: _____

Information to be released:
☐Psychological Test Results ☐Educational Evaluations
☐Written Treatment Information ☐Recommendations PLEASE DO NOT FAX OVER
☐Verbal Treatment Information ☐Any & All Information 10 PAGES, USE MAIL INSTEAD
☐Other: _____

I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments. If information pertaining to drug and alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal Confidentiality Rules (45 CRF Part 2). Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
I certify this authorization is made voluntarily, I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. A copy may be accepted in lieu of the original.
This consent will automatically renew each year unless notification to revoke is received in writing. I understand I may revoke this authorization at any time, except to the extent that action has already been taken.

Date: _____Signature of Patient/Parent/Guardian: _____

Date: _____ Signature of Witness: _____