LAFAYETTE PSYCHATRIC SERVICES
160 Kingsley Lane, Suite 204
Norfolk, Va. 23505
Phone (757) 489-4700 Fax (757) 955-8060

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 Lafayette Psychiatric Services FROM the above person/agency
__FROM Lafayette Psychiatric Services TO the above

I specifically authorize the disclosure and/or use of:

__Emergency room/Urgent care records	__Consultation Report	__Letters
__Hospital records (nursing & progress notes)	__Discharge Summary	__Psych test report
__Medication history	__Clinical Summary	
__Outpatient Progress notes	__Initial psych. Eval.	
__Substance abuse info.	__Admission note	
__Telephone discussion	__Lab reports	

__Other:_____

The requested records of 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 Lafayette Psychiatric Services. I understand that Lafayette Psychiatric Services 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 Lafayette Psychiatric Services by:_____
For (Provider's name):__Huma Hyder, MD
__Paul Callis, PA-C