Dear Patient:

Please complete the following release of information and RETURN IT EITHER BY FAX OR MAIL.

Please make sure to complete the entire form and to PROVIDE YOUR PHONE NUMBER so that can you can be contacted with any questions and to inform you of the record copy fee.

FEES INCURRED FOR REQUESTING A COPY OF YOUR RECORDS (in accordance with Virginia Code § 8.01-413):

* $20 search and handling fee
* Copy fee: $0.50 per page for pages l-50; $0.25 per page thereafter
* Postage (if applicable)
* $50 for a written treatment summary in lieu of copied records

Payment will be due when the records are ready for pick up or, if you need them mailed, a credit card payment will need to be received prior to the records being sent.

MAILING ADDRESS:

Susan Kinkead-Acree, MD, PLLC

1499 Chain Bridge Rd., Suite 100

McLean, VA 22101

TEL: 703-992-6537

FAX: 703-992-6539

Please call if you have any questions.

Thank you,

Dr. Kinkead-Acree

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Susan Kinkead-Acree, MD to disclose my protected mental health treatment, including any substance-abuse-related treatment, information as indicated on this form to the recipient listed below:

CONTACT INFORMATION

Contact name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Description of the information to be disclosed (check all that apply):

* Initial psychiatric evaluation
* Progress notes (therapy notes included)
* Telephone notes
* Labs
* Assessment questionnaires
* Physician coordination-of-care correspondence
* Medication prescription history
* Legal correspondence (if applicable)
* Medical records of other health care providers
* Verbal communication with contact listed above (no records to be sent)
* Written treatment summary (in lieu of copy of records)
* Records related only to specific dates of service (specify dates):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient signature Telephone number (required) Date