Susan Kinkead-Acree, MD

Dear Patient:

Please complete the following release of information and RETURN IT EITHER BY FAX, MY SECURE-SEND EMAIL PORTAL, OR USPS 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, if applicable.

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 1-50; $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. A credit card payment is required 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

WEBSITE: susankinkeadacreemd.net (Link to secure e-mail portal on Forms page)

Please call if you have any questions.

Thank you,

-Dr. Kinkead-Acree

Susan Kinkead-Acree, MD

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):

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

______________________________	______________________	____________
Patient signature	Telephone number (required)	Date

McLean Professional Park
1499 Chain Bridge Road
Suite 100
McLean, VA 22101

TEL 703-992-6537
FAX 703-992-6539
susankinkeadacreemd.net