PSYCHIATRY & WELLNESS, LLC

Patients Name: _____ Date of Birth: _____

Phone Number: _____ Previous Name: _____

_____ I authorize the release and/or exchange of information from the below individual, organization, or title release healthcare information of the above named client to/from RVA Psychiatry and Wellness, LLC.

Release Records From/To: _____

Address: _____

Phone Number: _____ Fax Number: _____

Effective Period: This authorization for release of information covers the period of healthcare from

a. _____ All past, present, and future periods.

Or

b. Start: _____ to _____

Extent of Authorization:

a. _____ All healthcare information

b. _____ Healthcare information relating to the following treatment, condition, or dates

Please Specify: _____

c. _____ Other: _____

Signature: _____ Date: _____

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