Independence Therapy Center, PC
Authorization for Release of Medical Information

Patient Name: ____ Date of Birth: ______________________
Social Security Number: ____
Home Phone: _______________ Cell Phone: ____________________ Work Phone________________
Address:____
Street City State Zip Code

PLEASE NOTE: COPY FEE MAY BE CHARGED FOR RELEASE

The above listed patient authorizes the Independence Therapy Center, 700 Independence Circle, Suite 3D, Virginia Beach, VA 23455; Phone: 757-473-8533 and Fax: 757-456-0616 to **release, exchange, and receive** medical records from/with: (circle all that apply)

Facility Name: ____
Facility Phone: _______________________________________Facility Fax: _______________________
Facility Address: ____
Street City State Zip Code

Type of information to Disclose:
____ Psychiatric Records: (date range) _________________
____ Psychotherapy Records: (date rage) ________________
____ Hospital Admission / Discharge Summary
____ Labs, X-rays, other diagnostic test results
____ Financial Records

The Purpose of Disclosure is:
____ Transfer of Care
____ Continuation of Care
____ Referral
____ Other: _______________________

Note: if these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

My rights
I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has been released in response to this authorization. Please see our Notice of Privacy Practices for instruction as to how to revoke this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ____
____

If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months from the date signed.

I understand that authorizing the disclosure of my health records is voluntary. I understand that I may inspect the information to be used or disclosed upon setting an appointment with Independence Therapy Center, PC Administration Staff; I also understand there may be a charge for this appointment. If I have questions about my health information and its release I can contact Independence Therapy Center, PC Administration Staff at 757-473-8533.

Signature:
______________________________________ Date: ________________________________
Signature of Patient or Patient's Legal Representative

____
Printed Patient Name
Relationship to Patient ____Parent/ Legal Guardian ____Power of Attorney