Supreme Healing Psychological Services

2101 Executive Drive, Suite 370, Hampton, VA 3666
Phone: 757-933-5386 Fax: 757-210-4197

MEDICAL RELEASE OF INFORMATION AUTHORIZATION

Patient Name: _____ Date of Birth: _____

Address: _____

SSN: _____ Phone Number: _____

I hereby authorize Supreme Healing Psychological Services to obtain/disclose health information including:

- ☐ All Records
- ☐ Psychiatric/Mental Health Record
- ☐ Medication History
- ☐ Substance Abuse/Drug Treatment
- ☐ Psychological Testing
- ☐ Lab Reports
- ☐ Progress Notes
- ☐ Care Plan
- ☐ Billing Records
- ☐ Insurance Information

For treatment date(s): _____ to _____ or ☐All dates of service

Release information to:

Name: _____

Address: _____

Phone: _____ Fax: _____

I hereby authorize the disclosure of the health information for the above-named patient. This authorization is valid for one year from the date of signature. I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

Signature: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:
☐ Patient is a minor: _____ years of age
☐- Patient is unable to sign because: _____

Name of Authorized Representative:

_____

Authority of representative to sign on behalf of the patient: ☐ - Parent ☐ - Legal Guardian ☐ - Court Order
☐ - Other: _____