Appalachian Psychiatry, PLLC
Thomas R. Olmsted M.D.
5 West Valley Street
Bristol, VA 24201
(276)628-4926
(276)644-9800 (fax)276-644-9808

PERMISSION TO RELEASE/OBTAIN INFORMATION

Patient's Name:_____D.O.B _____

This form gives Appalachian Psychiatry, PLLC permission to exchange verbal and/or written information concerning treatment services provided to the above named patient to the person or agency listed below.

My signature at the bottom of this form represents a waiver of my right to privileged communication only with the respect to release of information to Appalachian Psychiatry, PLLC or the person/agency specified below.

I give permission for Appalachian Psychiatry, PLLC: (check one)

_____to release information.

_____ to obtain information.

_____ to release and obtain information.

Appalachian Psychiatry, PLLC has my permission to release/obtain:

_____ office notes _____ lab reports

_____ discharge summary _____ history & physical

_____ other (please specify)_____ Purpose of Disclosure _____

Authorization applies only to the person or agency listed below:

Name:_____Fax:_____

Address:_____ Telephone:_____

I understand that I have no obligation to disclose information to the above named person/agency, and that I may revoke this consent at any time by informing Appalachian Psychiatry, PLLC in writing. In consideration of this consent, I hereby release Appalachian Psychiatry, PLLC from any and all liability arising therefrom. I understand that Appalachian Psychiatry, PLLC may not condition the provision of treatment on the signing of this authorization. I understand that there is the potential for the protected health information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provision of the HIPPA privacy rule. This release will be effective until the treatment is completed unless otherwise specified. This authorization extends to information placed in the record after the authorization was given, but before it expires. A mechanically reproduced copy of this release will be considered valid.

Patients Signature:_____Date:_____

Guardian's Signature:_____Date:_____

Witness:_____ Date:_____