Medical Records Release Authorization

By signing this form, I authorize Blue Ridge Psychological Center to release confidential health information, by releasing a copy of my medical records to the physician//person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release is as follows:

___ Complete medical record

___ Financial statement of office visits

Release my protected health information to the following physician/person/facility/ entity and/or those directly associated with my medical care:

Name:_____

Address:_____

City, State, Zip Code:_____

The purpose/reason for this release of information is as follows:

_____

_____

_____

_____
Printed Name of Patient or Legal Representative

_____
Signature of Patient or Legal Representative

_____
Date