Poplar Springs Hospital
350 Poplar Drive
Petersburg, VA 23805

Patient Name _____
D.O.B. _____
SSN# _____
Med Rec # _____

RELEASE/DISCLOSURE OF INFORMATION

Duration of this release is no longer than 1 year from the date of discharge and may only be used to release the information as specified below.

DATES OF TREATMENT: _____to discharge of patient.

I hereby give my consent for Poplar Springs Hospital to: release _____and/or obtain_____information, to _____ and/or from_____via_____verbal and/or_____written notification.

NAME: _____AGENCY/REL.: _____

ADDRESS: _____CITY/STATE:_____

PHONE #: _____FAX #:_____

This information is to be released for the purpose of: _____Continuity of care_____

REQUESTED INFO. (If available)	**DATE RELEASED**	**INITIAL**	**REQUESTED INFO. (If available)**	**DATE RELEASED**	**INITIAL**
[ ]Admission Notification	_____	_____	[ ]School Records	_____	_____
[ ]Admission Note	_____	_____	[ ]Discharge Summary	_____	_____
[ ]Psychiatric Evaluation	_____	_____	[ ]Discharge Instruction Sheet	_____	_____
[ ]Biopsychosocial History	_____	_____	[ ]Discharge Notification	_____	_____
[ ]Psychological Testing	_____	_____	[ ]History and Physical	_____	_____
[ ]Immunization Records	_____	_____	[ ]Individual Therapy Notes	_____	_____
[ ]**Substance Abuse Info**.	_____	_____	[ ]Family Therapy Notes	_____	_____
[ ]ER Records	_____	_____	[ ]Group Therapy Notes	_____	_____
[ ]**HIV**	_____	_____	[ ]Insurance Verification	_____	_____
[ ]Other _____	_____	_____			

COPY OF THIS RELEASE IS AS VALID AS ORIGINAL

As the person signing this consent, I understand that I am giving permission to the above-named provider or other third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but it is not effective until delivered in writing to the person who is in possession of my records. Documenting such as request on the Written Request of Restriction of Use & Disclosure of Protected Health Information form may complete this process. Federal Regulations 42 (CFR Part 2): also governs and prevents the release of HIV, alcohol and drug abuse information without specific written consent.

SIGNATURE OF PATIENT: _____DATE: _____

SINGATURE OF PARENT / GUARDIAN: _____DATE: _____

SIGNATURE OF WITNESS: _____ DATE: _____