AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MEDICAL INFORMATION

Patient Name:_____ Birth Date:_____

Social Security #:_____ Phone: _____

I authorize Rockingham Memorial Hospital to use or disclose my health information as described below:

Release information to
Raymond J Alderfer MD PLC,
110 Newman Avenue.
Harrisonburg, VA 22801
540-442-9900 (Phone); 540-442-9901 (Fax).

Purpose of disclosure: Patient request and Healthcare.

Sensitive Information including psychiatric care or psychiatric assessment, psychotherapy notes, and alcohol and/or drug abuse related information.

The specific records/reports to be disclosed include:

Transcribed Initial Psychiatric Evaluations from VBM chart, (5/1/06 – 3/29/13)

Dr. Alderfer's first Progress Note from the VBM chart.

Progress Notes from VBM chart (1/1/12 – 3/29/13)

Medication Log from the VBM chart

Psychiatric History and Physical Examinations for BHU (or MHC) and PHP (1/1/06 – 3/29/13)

Discharge Summaries for BHU or MHC (1/1/06 – 3/29/13) and

Psychiatric Consultations for RMH (1/1/06 – 3/29/13).

I understand that this authorization is voluntary. I understand that I can cancel this authorization by written request to Release of Information, Health Information Management Department, but it will not affect information that was released prior to notice of cancellation. I understand that this authorization will expire in 1 year from the date of my signature below; or until_____(not to exceed 1 year). I understand that once my information is released, it may no longer be protected by federal privacy regulations. Alcohol, drug, HIV, ARC and/or AIDS information, if present, will be disclosed as I have requested above. I understand this information is protected by federal and state privacy laws and may not be disclosed without authorization, unless required or permitted by law. I understand that I will be charged for copies of medical records.

_____

Patient Date of Authorization

_____

Print Name Relationship to Patient

Mail this form to: RMH, Release of Information HIM Dept., 2010 Health Campus Drive, Harrisonburg, VA 22801 or Fax to: RMH, Release of Information, 540-564-7274.