Melissa B Nelson, MD
Mental and Behavioral Health
mnelsonmd.com
Incoming Fax: 804 286 2195
Telephone: 804 286 2195

Release to Exchange Information

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH / PHYSICAL HEALTH / EDUCATIONAL RECORD (Also known as Protected Health Information)

* indicates a required field

*Client's name:

*Date of Birth:

Parent / Legal Guardian Name (if applicable, for minor clients):

*Your Address (mailing):

*Your Phone Number:

*Your Email Address:

*Your relationship to client: (circle)

- Self
- Parent/legal guardian
- Personal representative
- Other

I authorize _____
to exchange information from my health records, mental health records, educational records or reports, therapeutic assessments, and questionnaires or screening tools which may include information about treatment dates, clinical content, and assessment results with Melissa Nelson, MD through her independent practice.

* The following information is to be released (circle all that apply):

- All of the below
- Contact Information / Demographic Information
- Intake Forms (i.e., Personal History, Symptom Checklists)
- Recent Progress Notes
- Medication History
- Diagnostic/Evaluation Reports
- MCHAT-R Checklist

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- Vanderbilt Scales
- Questionnaires
- Growth Curves
- Therapy Evaluations and Reports
- Psychological Assessments or Educational Testing
- Complete Health Record (from primary care provider)
- Other:

*** Records released/exchanged may encompass these dates of treatment (i.e., 2024-2025, "all treatment dates"):_____**

_____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

*** Signature of Patient (ages 18 +)**

Sign here

*** Date:**

Parent / Legal Guardian if under 18 years old

Sign here

Parent / Legal Guardian Name: