CLAYTOR MEMORIAL CLINIC
1625 Franklin Street, Rocky Mount, VA 24151
Phone: 540-483-0373 Fax: 877-803-9136
admin@claytorclinic.com

Authorization for Release of Information

Patient: _____ DOB: _____

I hereby authorize ___Claytor Memorial Clinic/Richard L. Claytor, Jr., MD/Monica L. Wiltjer, PA-C_____
[Name and address(es) of physician, hospital, or health care provider]

to release/obtain/exchange my personal health and medical information as described below with the following person(s)
_____
_____
[*Name and address(es) of person(s) to receive/release/exchange information*]

for the following purpose(s):_____

This information includes (check all that apply):

- ☐ Medical Records
- ☐ Educational/Academic Records
- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation
- ☐ Court Report
- ☐ Other (describe below)
- ☐ Neurological Evaluation
- ☐ Behavioral Reports
- ☐ Teacher Reports
- ☐ Treatment/Discharge Summary
- ☐ Substance Abuse Information
- ☐ Urine Screen/Breathalyzer Results

_____

The information to be shared covers the following dates of service:

From (date) _____ to (date or event) _____

This authorization will expire on _____ (Date or event), unless revoked by the undersigned or in one year from todays date.

This release, made freely and voluntarily, shall remain for the period noted above and may be revoked at any time with written notification executed by the responsible party noted below, except to the extent that action based on this consent has already been taken. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for treatment or benefits.

I understand that I may inspect or receive a copy of the information described on this form if I ask for it.

I understand that if the person or entity that receives the above information is not a health care provider or a health plan covered by federal privacy regulations, the released information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from redisclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A photocopy, fax, or electronically transmitted version of this document has the same force and effect as the original.

_____ _____
Signature of patient Date

_____ _____ _____
Signature of parent/guardian/client's representative Printed Name of Representative Date

If signed by other than client, indicate relationship: _____

If prepared and/or witnessed by a CMC Staff Member: _____ (Staff member name)