Fields Behavioral Health
53 S. Loudoun St
Lovettsville VA 20180

To obtain your full psychiatric record from Fields Behavioral Health:

Please complete the release of information and the invoice attached to this letter. Records are released either by disc or in paper form, depending on size. Please complete the form below to allow for your records to be released. Please allow up to 4 weeks for processing and shipping of records, from the date the form and payment are received at the address noted above.

Thank you,
Fields Behavioral Health

Client/Representative initials_____

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Fields Behavioral Health Record Release Invoice

Party receiving records: The patient, as noted above or other party if listed:

_____

Address to remit records to: _____

_____

Record Release Fee: $50, which includes the base record fee and average per page fee and shipping and handling.

Payment: All payment must be via check. Please remit this form with a $50 check to the address found on the letter head. Please make checks payable to "Fields Behavioral Health."

By signing this document, you authorize the shipment of your records and certify that the address provided is a secure location where your records can be sent without risk of being observed by unauthorized persons. You also agree to payment for such records as noted above. In addition, you release Fields Behavioral Health of any damages claims related to the outcome of records after the records have left our possession and have been mailed via USPS.

_____	_____	_____	_____
Patient name	Patient/Parent Signature	Name of signer	Date

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Authorization to Release Confidential Records and Information

A. Identifying information about me/the patient

Name: _____ Date of birth: ___/___/_____ Name of parent/guardian (if not self): _____

B. Date or time this ROI will expire: One time request for release of records.

C. I authorize the release of information between the parties listed below:

From (Source): Fields Behavioral Health	To (Recipient):
Address: 53 S. Loudoun St Lovettsville VA 20180 Phone: (540) 554-1037 jfields@fieldsbehavioralhealth.com Phone: 540-554-1037 Email: jfields@fieldsbehavioralhealth.com	Address: Phone: Fax: Email:

The records to be disclosed are the patient's **full treatment record**. I authorize the transfer of these records for the following purpose(s) or uses: Further mental health evaluation, treatment, or care.

I authorize the source named in section B above to share by telephone, electronic or postal transmission of records, and/or face to face with the recipient in section B any information that can assist with my/the patient's receiving treatment. I understand that the source of the information has no control of it after it has left the source's premises. I understand that I may revoke this ROI authorization, but that doing so will not bring back the information that was released before the date of the revocation. I can do this at any time by writing to the source named in section B. I have had the provisions of this form explained to me and believe that I fully understand this ROI.

I understand that these records contain substance abuse and treatment history. This type of records has special protections under federal law. I am consenting to the release of all records (or as noted above), including substance abuse records involving current and prior use, as well as treatment.

Signatures:

_____ _____
Signature of patient/guardian/representative Date

_____
Printed name of patient

Name of person signing form if different from patient name: _____