Fields Behavioral Health
53 S. Loudoun St
Lovettsville VA 20180
Phone: (540) 554-1037
jfields@fieldsbehavioralhealth.com

Authorization to Release Discharge Summary to Third Party

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 release of discharge summary.

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 only records to be disclosed is the patient's outpatient **treatment discharge summary**. 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: _____