Seaside Behavioral Health
Health Information/Records Request

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Home Phone: _____ Cell Phone: _____

Address: _____
Street City State Zip Code

The above listed patient authorizes:

Facility Name: _____

Facility Phone: _____ Facility Fax: _____

Facility Address: _____
Street City State Zip Code

To disclose my health information to: Seaside Behavioral Health
1072 Laskin Road, Suite 104
Virginia Beach, VA 23451
Phone: (757) 648-8605
Fax: (757) 648-1363

To release the following information: (* MUST contain date range)

( ) Psychiatric Records * _____ to _____
( ) Psychotherapy Records * _____ to _____
( ) Laboratory / Pathology Records
( ) History and Physical Examination
( ) Consultation Report
( ) Discharge Summary
( ) Drug / Alcohol Abuse Treatment Records
( ) Inpatient Hospital Records
( ) Neuropsychological Testing/Report

State the Purpose of the Disclosure:

( ) at my request (patient)
( ) continuity of care
( ) employment reasons
( ) disability / life insurance
( ) transfer care
( ) other (specify) _____

If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information. Please Initial: _____

Read and Sign:

- I understand I have the right to inspect and obtain a copy of the records to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

- I understand this authorization is voluntary. I understand the person(s) or organization(s) authorized to request and/or disclose this information may not condition the provision of treatment on the provision of an authorization

- I understand I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the office authorized to make the release. I understand the revocation will not apply to information that has already been released in response to this authorization.

- This authorization will expire on the following date: _____. If I do not specify an expiration date, this authorization will expire 12 months form the signature. I understand that a Medical Records coping fee may apply for the release of my medical records. ($10 search/handling, $.50 per page and $.25 per page thereafter)

_____ _____
Patient/Guardian Signature /Date Witness Signature – Required for Mental Health /Date

_____ _____
Parent/Guardian Representative: Print Name and Relationship Signature of Child (Age 15 -17) /Date