Consent to Release/Request Confidential Information

Pinnacle Behavioral Health

Pinnacle Psychological Associates

540 Fort Evans Rd., Suite 200

Leesburg, VA 20176

I _____ (Patient Name) hereby authorize _____ (Clinician Name) and staff at Pinnacle Behavioral Health/Pinnacle Psychological Associates, to talk with and/or release written documentation (including transmittal by fax, personal conversation, and or written document) to the following party:

Name _____

Address _____ Phone Number_____

Information to be disclosed to include (please check each box below):

❑ Dates of Sessions

❑ Recommendations

❑ Discharge Summary

❑ Assessment

❑ Other _____

I understand that Federal law and regulations do not protect any information about suspected child or elder abuse, or harm to self or others from being reported under State law to appropriate state or local authorities.

I understand that my records are protected under Federal Regulation 42 CFR and regulations governing records relating to Alcohol and Drug Abuse, and cannot be re-disclosed without written consent, except as specifically stated by law. I also understand that I may revoke this consent at any time except to the extent that action has been taken or in the event of expiration. This authorization expires one year from today's date.

I have read the above CONSENT AND RELEASE and agree to its content:

Signature: _____Date:_____

Witness Signature: _____ Date:_____