Riverbend
PSYCHIATRY

Consent for Release of Confidential Mental Health/Substance Abuse Records

Patient Name Date of Birth

Authorize: Riverbend Psychiatry 509-960-7287 phone
Jay D. Schmauch, DO 509-321-7065 fax

Release to or ***Obtain from*** (circle one or both):

Name or Facility

Address City State Zip Code

Phone Number Fax Number

For the purpose of: Continued Care Personal Litigation Insurance Claim
(Circle one) Other: _____

To Be Disclosed:
____Entire record
____Last chart note
____Lab records
____Assessment
____ Other: _____
____All records from date forward: _____
____Allow telephone contact
____Psychological/drug testing
____Report/psychiatric evaluation

RESTRICTIONS: _____

This consent includes authorization to release alcohol, drug abuse, and mental health records obtained in or for the diagnosis, treatment, consultation or evaluation. I understand that I may revoke this consent at any time, except to extent the action has already been taken in reliance hereon and if not revoked sooner in writing. The consent is valid for the duration of treatment, unless otherwise revoked in writing. You are not required to sign this consent in order to receive treatment, unless this is for a Fitness for Duty Exam or for participating in a medical research study.
Please note when you request records be released to a third party, that party may NOT be subject to re-disclosure or privacy regulations.

Patient Signature Date