Authorization for Release of Information and Referral for Mental Health Medication Management

Authorization for Release of Information (TO BE COMPLETED BY GUARDIAN OR PATIENT)

I _____ (Guardian or Patient if independent) hereby authorizes W Lawrence Daniels and/or his practice entities to exchange information about _____ (Patient), born on _____ (Date of Birth) with the provider below for the purposes of continuity and coordination of mental health care:

Name of individual and/ or organization: _____
Address/Phone Number (Include Fax Numbers, Voice Phone Numbers, and Email Address if available):

_____

_____

This information includes (Check All That Apply or Check Here for All Records ☐):

☐ Medical Records	☐ Teacher Reports	☐Substance Abuse Evaluation
☐ Neurological Evaluation	☐ Psychological Evaluation	☐ An on-going exchange of information
☐ Educational/Academic Records	☐ Treatment/Discharge Summary	☐ Past Services (Verbal Exchange or Reports)
☐ Behavioral Reports	☐ Court Report	☐ Other (describe below)
☐ Psychiatric Evaluation	☐ Urine Screen/Breathalyzer Results	

This authorization is valid from _____ to _____, unless revoked by the undersigned. The absence of dates indicates indefinite and continuous authorization.

I authorize the use of standard email services understanding that information may be compromised. Yes ____ No ____ (Please Initial)

Consent Signature(s)

_____ _____ _____
Patient Date Parent/Guardian/Authorized Representative

Witnessed by: _____ _____
Non-Family Member or Notary Signature Witnesses Printed Name

_____
Witnesses Address or Notary Information

Referral for Mental Health Medication Management (TO BE SIGNED BY THE PRIMARY CARE PROVIDER)

In accordance with DEA requirements for physical presence for the prescription of controlled substances, I refer the above listed patient to W Lawrence Daniels, PhD, RN, CPNP for mental health medication management by telehealth audio and visual services. I last examined him/her in-person on _____/____/_____ and find telehealth an appropriate venue for mental health assessment and care.

_____ _____ _____ _____
Provider Name Printed NPI Signature Date

Referred to W Lawrence Daniels, PhD, RN, CPNP, PMHS with these practice entities:

James Barry-Robinson Institute Intensive Outpatient Services 6330 North Center Dr. Bldg. 13 Ste 141 Norfolk, VA 23502-4008 (757) 524-5585 Fax (757) 937-3938	Beach Counseling Center 1064 Laskin Rd. Virginia Beach, VA 23451 (757) 233-1500 Fax (757) 222-3833	Adapt Well, PLLC 5705 Lynnhaven Pkwy Ste 104 PMB 1078 Virginia Beach, VA 23464-8533 (757) 576-4946 Fax (757) 455-5238

Revocation Signature(s) I _____ Revoke my consent for W Lawrence Daniels to exchange information with the above-named individual/organization as of this date _____.

_____ _____ _____
Above Named Patient Printed Name Date Parent/Guardian/Authorized Representative Signature

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.