Westhampton Family Psychologists, P.C.
1503 Santa Rosa Road Suite 105 Richmond, VA 23229
phone: 804-673-0100 • FAX: (804) 673-8054

Initial Here:

Authorization to Release Protected Medical Information

Patient's Last Name:	First:	Date of birth:
Street Address:		Cell Phone:
City:	State:	Zip Code:

I hereby give Samantha M. Winfrey, NP authorization to (specific):

☐ Release information to:	☐ Obtain information from:	☐ Discuss information with:
Company/Provider/Person Name:		
Address:		
Phone:	Fax:	

Covering the period(s) of treatment from_____to_____/ ☐ ALL

Information Requested:

- ☐ Records – Date(s) specified above
- ☐ Lab Work
- ☐ Records DO NOT need to be sent

For the purposes of:

- ☐ Coordination of care w/ another provider
- ☐ Moving/Transferring Care
- ☐ Insurance/Disability/Legal

☐ Other (specify)_____.

I understand if records are being requested, I must allow a two week processing period.

I understand this authorization will expire in ONE YEAR unless otherwise indicated in writing.

I understand I may revoke or edit this authorization at any time by providing written notification to Samantha M Winfrey, NP.

_____.

Printed name of Patient or Authorized Representative **Date**: / / .

_____.

Signature of Patient or Authorized Representative