River Road TMS, LLC

5101 Monument Ave., Suite #204
Richmond, VA 23230
P: 804-406-4773
F:804-430-5645

Consent for Release of Confidential Health Information

Name:_____

Date of Birth: _____

I hereby authorize River Road TMS, LLC to disclose to _____ and/or _____ obtain from:

_____

_____

(Name of Provider or Individual, including address, phone number and fax number)

_____

_____

Description of Information to be disclosed/obtained:

____ All TMS Treatment Notes
____Full Medical Record
____ Visit Verification
____ Billing/Payment Information
____ Other: (Please specify)

____ TMS Evaluation Note Only
_____ Referring Provider Treatment Update Letters

_____

Purpose:

This information may be disclosed or obtained in connection with my psychiatric treatment or coordination of overall healthcare. If the purpose is other than as specified above, please specify:

_____

Revocation

I understand that I have a right to revoke this authorization at any time by sending a written notification to River Road TMS, LLC by mail to 5101 Monument Ave, Suite 204, Richmond, VA 23230 or by fax to 804-430-5645.

Expiration

This release will expire one year from the date of authorization listed below unless otherwise specified. If other than one year, please list requested expiration date: _____.

I understand that once the information is released pursuant to this authorization, River Road TMS, LLC. providers have no control over what an authorized recipient may do with the information.

By signing below, I acknowledge I have read and understood the information above and understand the nature of this release and that I am giving my permission for the disclosure of confidential health care information.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date**: _____