P***otter Henderson, M.D.***
Child, Adolescent & Adult Psychiatry
3772 Shore Drive, Suite 2, Virginia Beach, VA 23451
Phone: 757.708.2149 Fax: 757.644.1432

Release of Information

I, _____ , authorize M. Potter Henderson, M.D. to obtain information from and share information with:

_____

_____

_____

_name of doctor/hospital/person/agency address phone/fax

I understand that the information may include the following:

- Assessment including diagnosis
- Treatment summary and recommendations
- Psychological testing or consultation
- Medical information and medications prescribed
- Drug and alcohol history and treatment
- Other: _____

Reason for release of information:

_____Continuity of care

_____Other: _____

I understand that I may revoke this release/authorization at any time by giving written notice to Dr. Henderson, except to the extent that action has already been taken to comply with this release. Without such revocation, this release/authorization will expire one year from the date of my signature.

_____ _____

Signature of Patient Date