capa
child & adolescent psychiatry associates, pllc
1135 cully road, suite 100
cordova, tn 38018
phone 901-752-1980 fax 901-737-5982

Jerry Heston, MD
Margaret A. Tom, DO
Elizabeth Vannucci, MD
Annie Naik Gadiparthi, MD
D. Andrew Elliott, MD

Release of Information

For purposes of ongoing care and treatment, I (We) hereby give consent for release of psychological/medical/educational information and records regarding me (us) to and between:

CAPA, Child and Adolescent Psychiatry Associates and:

_____
(name of doctor, school, clinic, hospital, parent, family member etc.)

_____
(address)

_____
(city) (state) (zip code)

(Phone)_____ (Fax)_____

Specifically, I authorize _____Evaluations, _____Progress Notes, _____Discharge Summaries, ____Lab Results

_____ Other (please specify)_____

NOTE:
*If you do **not** want certain parts of your records released, please initial the lines beside the type of information you do **not** want released. Otherwise, your records will be released as specified above.*
_____ Substance Abuse, if any ____AIDS/HIV, if any ___Psychological or psychiatric conditions, if any

_____ Other (please specify) _____

I understand that I may revoke this authorization at any time and that unless any earlier date is specified, it will automatically expire one year from the date below. I understand that a copy of this authorization may be used in place of the original. I also understand that CAPA has no control over information released to anyone else and that such information may be disclosed by the recipient.

This release is regarding: Patient's name: _____

Date of Birth: _____

_____ _____
Patient Date

_____ _____
Parent or Legal guardian Date

_____ _____
Witness Date