



AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL PSYCHIATRIC INFORMATION

The child is referred for admission to **TIMBER RIDGE SCHOOL**, a Residential Treatment Center for youth between the ages of 10 and 18.

I hereby give my permission to release the Psychiatric Discharge Summary of:

Student's Name: _____ Birth date: _____

FROM:
Name of Facility _____ Psychiatrist: _____

Address _____

Phone Number () - _____

FAX Number () - _____

TO: TIMBER RIDGE SCHOOL
Attn: Don D. Lee, MD
P.O. Box 3160
Winchester, Virginia 22604
FAX: 540-888-4512

Offering behavior descriptions and dynamics, intellectual assets and deficits, presence and extent of organic manifestations, and general course to date in any of these areas where such information is available. Psychiatric diagnosis along with respective prognosis is important for our planning. Your impressions of treatment needs, ability to benefit from a group living experience, and any other observations would be helpful.

As only those applications supported by complete evaluations can be considered, a comprehensive report is required.

Please return a copy of this release with your report.

I understand that no limitations are placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse. I understand what information has been requested and have been explained the benefits/disadvantages of releasing this information. I further understand that the provision of services is contingent on the release of this information and I voluntarily consent to the release of this information.

This authorization will expire in two years on _____
Date

Signature of Parent or Legal Guardian _____ Date _____

***Any redisclosure of confidential information by the recipient(s) is prohibited
except when implicit in the purposes of this disclosure.***

Date of Last Revision: 10/6/2010