Riverview Psychiatry, LLC
Marie Beasley, DO
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Phone: 423-443-2120
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Authorization for Disclosure of Patient Information

I authorize Dr. Marie Beasley, DO and

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

To exchange information about:

Name _____ DOB _____

Including but not limited to medical records, lab results, psychological testing, medication records, school reports, etc. This information is to be used solely for the purpose of diagnostic evaluation and treatment or other: _____

This authorization shall become effective immediately and shall remain in effect until end of treatment. This consent is also subject to revocation by the undersigned at any time between now and the release of information by the sending person, agency, or institution.

Patient/Parent Guardian Signature _____

Date _____