Carolina Psychiatric & Wellness
EVERY MIND MATTERS

2800 Village Way | Trent Woods, NC 28562
Phone 252-637-7300 | Fax 252-637-1772

Authorization for Release of Protected Health Information

NAME: _____ DATE OF BIRTH: _____

(Place an X in the appropriate spaces)

(Name, Address, Phone/Fax of Doctor's Office, Person, etc.)

[ ] Release Records

[ ] Receive Records

[ ] Receive and Release Records

(Written or Verbal communication)

For the following dates of rendered services:

THIS DATE SHALL INCLUDE THE FOLLOWING INFORMATION: (Mark all that apply)

[ ] ALL records (excludes "psychotherapy notes" as defined in 45 CFR 164.501)

[ ] Psychiatric evaluation/diagnosis

[ ] Psychological evaluation/diagnosis (excludes "psychotherapy notes" as defined in 45 CFR 164.501)

[ ] Psychotherapy Notes (at the discretion of the therapist)

[ ] Current medications

[ ] Other_____

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PURPOSE: The purpose of this disclosure is to improve assessment, treatment, planning, and share information relevant to treatment, continuity of care and, when appropriate, coordinate treatment services. This disclosure is at the request of the individual client or his/her legal representative.

Unless revoked in writing, this consent shall be valid for 365 days from the date of signing this contract, not to exceed one year.

FORM OF DISCLOSURE: Unless you have specifically requested, in writing, that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that is deemed appropriate and consistent with applicable law, including, but not limited to, verbal, written, or electronic format. The doctrine of informed consent has been explained to me, and I understand the contents to be released and the need for the information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent in writing at any time, except to the extent that action based on this consent has been taken. I also understand that revocation of this consent will not condition my treatment.

I understand that the HIPAA privacy law protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from re-disclosing it. I understand that mental health and development disability information is protected by N.C. State law (G.S. 122-C), and substance abuse treatment information is protected by federal law (42 C.F.R., Part 2), and HIV/AIDS information is protected by N.C. State law (G.S. 130A-143).

SIGNATURE OF CLIENT: _____ DATE: _____

SIGNATURE OF LEGALLY RESPONSIBLE PERSON:

_____

Printed Name of Legally Responsible Person:

_____

[ ] Parent [ ] Guardian [ ] Other _____

WITNESS: _____ DATE: _____

(OFFICE PERSONNEL ONLY)