NC Neuropsychiatry

attention & memory centers
www.ncneuropsych.com

Chapel Hill | Charlotte | Raleigh |

RELEASE OF INFORMATION

Patient:_____DOB: _____

Address:_____

City:_____State:_____Zip Code _____

Information Released From:

_____
Name (Health Care Provider)

_____
Address

_____
City State Zip

_____
Phone Fax

Information Released To:

_____
Name (Hospital, Agency, MD)

_____
Address

_____
City State Zip

_____
Phone Fax

Reciprocal Authorization for Release of Information (Check if applicable)
_____A reciprocal authorization allows NC Neuropsychiatry to have continuous dialogue between the medical personnel of NC Neuropsychiatry and the individual or group identified above.

Description of Information to be Released: This authorization is for full disclosure of the patient's medical records including clinical findings, diagnosis, treatment, assessment, laboratory results, progress notes, psychotherapy notes, recommendations for further care, names of health care personnel, dates of hospitalizations, charges, and visits. All records are kept confidential and shared only with pertinent personnel involved.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include this information. I choose to keep the following information confidential (initial each that you wish to keep confidential): _____ HIV infection, _____ AIDS or AIDS related conditions, _____ alcohol abuse, _____ drug abuse, _____ psychological or psychiatric conditions, _____ genetic testing.

Purpose of Release of Records: (initial **one**)

_____ Continuing Treatment _____ Personal _____ Legal Involvement _____ Worker's Compensation
_____Disability Determination _____ Moving _____ Insurance _____ Other

I understand that this consent is only valid for one (1) year from _____ unless signed for:
Today's Date

- establishment of financial benefits in which case the consent will be valid until the end of the benefit period
- release of information to the Department of Motor Vehicles, the Court and the Department of Correction for information needed to reinstate driving privileges. The consent will then remain valid until the reinstatement of driving privileges

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any medical personnel of NC Neuropsychiatry, or any other individual listed above to disclose my protected health information as described on this form to the recipients listed. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. This authorization shall be valid for one year from signature. I hereby release NC Neuropsychiatry from all legal responsibility or liability that may arise from this authorization.

_____ _____
Patient or Legal Guardian Signature Date Witness Signature Date

By signing here, I choose to revoke this authorization for the party listed above.

_____ _____
Patient or Legal Guardian Signature Date