

**RELEASE OF INFORMATION**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Information Released From:**

**Information Released To:**

\_\_\_\_\_  
Name (Health Care Provider)

\_\_\_\_\_  
Name (Hospital, Agency, MD)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
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, visits, and any other information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted diseases. All records are kept confidential and shared only with pertinent personnel involved.

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

- \_\_\_\_ Continuing Treatment
- \_\_\_\_ Disability Determination
- \_\_\_\_ Worker’s Compensation
- \_\_\_\_ Personal
- \_\_\_\_ Moving
- \_\_\_\_ Insurance
- \_\_\_\_ Legal Involvement
- \_\_\_\_ Other

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 This authorization shall be valid for the duration of the patient’s treatment at NC Neuropsychiatry or until rescinded in writing. 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

1829 E. Franklin Street, Bldg. 400  
Chapel Hill, NC 27514  
T 919 933-2000  
F 919 933-2830

6911-100 Shannon Willow Road  
Charlotte, NC 28226  
T 704 529-4101  
F 704 529-6655

2605 Blue Ridge Road, Suite 225  
Raleigh, NC 27607  
T 919 785-5055  
F 919 573-6689

10880 Durant Road, Suite 124  
Raleigh, NC 27614  
T 919 800-2442  
F 919 800-2440