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 This authorization shall be valid for the duration of the patient's treatment at NC Neuropsychiatry or until rescinded in writing.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