CAROLINA COMPLETE PSYCHIATRY

Authorization to Disclose Health Information

I,____(Name) Date of Birth:____________

of____

____(Address)

Authorize: Carolina Complete Psychiatry of 5950 Fairview Rd, Ste 708, Charlotte NC 28210

Phone: 704-503-9884 Fax: 704-870-3968 to release/obtain my medical information to:

Organization and/or Person:____

Relationship:____________________________

Address:

____

____

Phone: _____________________________ Fax:________________________________

I hereby authorize Carolina Complete Psychiatry to release/obtain copies of Psychiatric Evaluation, Psychiatric Summary, Progress Notes, Psychotherapy Notes, Drug and Alcohol, HIV and Medical information except for restrictions listed here:

____

From the health care record pertaining to my hospitalization/treatment of

_______________________________________ (if blank, for one year prior to date signed)

(Specify dates of treatment)

This information is being disclosed for the following purpose(s): (Check at least one)

( ) Changing provider	( ) Continuing Care	( ) Insurance
( ) Legal Purposes	( ) Social Security/Disability	( ) School
( ) At my (patient) request	( ) Workers Compensation	( ) Second Opinion

This authorization is valid until one year from the date signed. I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time in writing. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider for the sole purpose of creating health information, service may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_X____ Date: ____________

Printed Name

_X____

Signature

Should you choose to REFUSE/REVOKE PERMISSION to release the above listed information, sign:

____ Date: ____________

Signature