# CAROLINA COMPLETE PSYCHIATRY

***Authorization to Disclose Health Information***

I,_____ Date of Birth:_____
(Patient's Name)

of_____
(Address)

_____

Authorize: Carolina Complete Psychiatry of 5970 Fairview Rd, Ste 430, Charlotte NC 28210
Phone: 704-503-9884 Fax: 704-870-3968 to release/obtain my medical information to:
Organization and/or Person:_____
Relationship to patient:_____
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 as long as you are an active patient at Carolina Complete Psychiatry. I understand that this authorization is valid for the period of time needed to fulfill its purpose, except for disclosures 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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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 of Patient or Parent/Legal Guardian (and relationship if patient is a minor)

X_____
(Signature of Patient or Parent/Legal Guardian)

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

_____ Date: _____
(Signature of Patient or Parent/Legal Guardian (and relationship if patient is a minor)