AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:____

Date of Birth:____________________ Social Security Number:________________________

Section 1: Person or Organization:____

Street Address:____

City:__________________________________ State: _______ ZIP Code: ______________________

Phone: (_____)_____________________________ Fax:(______)______________________________

☐ **To Release Information to Another Party**: I authorize the release of information/ records specified below to the person or organization listed in section 1, from West Cary Psychiatry. This is being requested for the purpose of ongoing treatment.

☐ **To Release Information to West Cary Psychiatry:** I authorize the release information/ records specified below by the person or organization listed in section 1, to West Cary Psychiatry. This is being requested for the purpose of ongoing treatment.

Section 2: The specific protected health information I am requesting to be disclosed is:

___ Progress/Treatment Notes
___ Records related to Substance Abuse
___ Laboratory Results
___ Diagnostic Imaging Reports
___ Continuity of Care/Coordination of Care communications between providers
___ Admission History and Physical
___ Discharge Summary
___ Psychological Testing
___ Other: ____________________________________

Dates of treatment: From__________________________ to ___________________________________

Section 3: I understand that information or records sent to West Cary Psychiatry may be incorporated into my medical record and will become part of my protected health information at West Cary Psychiatry. This authorization will expire on__________ , or in one year from the date of the signature below if no date is indicated, or sooner if I revoke this authorization in writing. I understand that my treatment will not be conditioned on whether I sign this authorization.

____
Signature of Patient (or representative)

____
Printed name of Representative (if not patient)

____
Date Signed

____
Relationship of Representative to Patient

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