HRC BEHAVIORAL HEALTH & PSYCHIATRY, PA
CONSENT to RELEASE INFORMATION

100 Europa Drive, Suite 260
Chapel Hill, NC 27517
Ph: (919) 929-1227 Fax: (919) 968-2575

4201 Lake Boone Trail, Suite 201
Raleigh, NC 27607
Ph: (919) 785-0384 Fax: (919) 785-0038

Name_____ DOB_____

This form, when completed and signed by you, authorizes the release of protected information from your clinical record to the person(s) you designate.

I authorize the exchange of information between HRC Behavioral Health & Psychiatry and the following:

1. **Primary Care, Referring Physician, or Therapist**

   Name_____Organization _____

   Office Phone_____Fax _____

   Address_____ City_____ State_____ Zip_____

   Extent of information to be released includes: Summary of diagnosis and treatment_____

   _____

2. **Other (e.g. a family member, friend, or organization who may call on your behalf about billing, scheduling, etc.)**

   Name_____ Relation to you_____

   Phone_____ Address_____

   City_____ State_____ Zip_____

   May they schedule you? ☐ **Yes** ☐ **No**

   Extent of information to be released includes:_____

   _____

3. **Other (e.g. a family member, friend, or organization who may call on your behalf about billing, scheduling, etc.)**

   Name_____ Relation to you_____

   Phone_____ Address_____

   City_____ State_____ Zip_____

   May they schedule you? ☐ **Yes** ☐ **No**

   Extent of information to be released includes:_____

   _____

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This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with, these individuals or companies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information.

☐ I am requesting this information exchange for the purpose of Continuity of care.

This authorization will remain in effect for **two years** unless you designate a different time period below. You may revo ke this authorization at any time by giving us written notice.

Expiration if different from above: _____

This authorization is fully understood and is voluntarily made on my part.

*Patient's Signature*_____ *Date* _____

OR

Parent or legally appointed representative's signature _____

Relationship if not parent _____*Date*_____

Witnessed By: _____*Date*_____

3/2019 revised

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.