CARY BEHAVIORAL HEALTH PC

PHONE (919) 466-7540 FAX (919) 466-7543

CONSENT FOR RELEASE OF PATIENT INFORMATION

Name:____________________________________ DOB:________________________

Address:____

I hereby authorize Cary Behavioral Health, P.C. to ◻ release ◻ obtain
Specified information in my medical/patient/educational record for the purpose of continued medical care.

____
(Individual, Facility, or Organization)

____
Address

__________________________ __________________________
Phone number Fax number

Information to be Used or Disclosed include the available items checked below:

◻ Hospitalization ◻ Consultation Report ◻ Discharge Summary

◻ Initial Evaluation ◻ History & Physical ◻ Treatment Notes

◻ Psychological Testing ◻ Labs ◻ Other_______________

Dates of Treatment: ____

I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information. I understated that my medical record may contain information regarding testing of drug and/or alcohol and diagnosis or communicable, venereal disease or AIDS. I hereby acknowledge that this consent is truly voluntary. I understand the potential exists for health information that is release with my authorization to be re-disclosed by the recipient and to be no longer protected by the Federal HIPAA law. I further acknowledge that I have the right to revoke this authorization at any time by giving written notice Cary Behavioral Health, P.C. Please note that CBH does not re-disclose third parties medical records. This release will expire one year from the date of this form. **The N.C. medical record fee, Section 90-410, allowed is seventy-five cents (75₡) per page for the first 25 pages, fifty cents (50₡) for pages 26 through 100, and twenty-five cents (25₡) for each page in excess

of 100 pages, with a minimum fee of $10.00

______________________________________ ____________________

Patient (or Guardian's) Signature Date