EASTOVER PSYCHOLOGICAL & PSYCHIATRIC GROUP, P.A.
3303 LATROBE DRIVE
CHARLOTTE, NC 28211
PHONE: (704) 362-2663 FAX (704) 362-2836

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

********* You must complete this from in its entirety or it will be returned to you***********

PLEASE ALLOW UP TO 30 DAYS TO PROCESS YOUR REQUEST

Patient Name:______________________________ Date of Birth____________________,

Hereby authorize: SS#____________________

Name:____________________ Address:______________________________

Telephone #:______________ Fax #:______________ City/St/Zip:______________

To release my medical information to:

_____ **Attorney** _____ **Physician** _____ **Therapist** _____ **Other**______________________

Name:____________________ Address:______________________________

Telephone #:______________ Fax #:______________ City/St/Zip:______________

I authorize the use or disclosure of my personal health information as described below:

☐ Any and all records including **mental health, psychotherapy notes, HIV –related information, Sexually Transmitted Disease, and/or information related to the diagnosis and treatment of psychiatric disabilities, and/or substance abuse records**, covering the period of time ______________ to ______________

☐ Other or Exceptions: ____.

The information is being disclosed for the following purpose(s):

O Changing physicians	O Second Opinion
O Continuing Care	O Legal
O At my (patient) request	O Insurance
O Workers' Compensation	O School

This authorization is valid until______________ (up to one year). 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 disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the second page of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information. However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (42 CFR & 2.32), the Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CFR PART 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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 (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

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

Signature of Individual/Guardian/Personal Representative	**Date Signed**	**Print Name**
Signature of Witness:	**Print Name of Witness**	

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: ______________________________

FOR OFFICE USE ONLY
Staff Person Releasing Information
Date Information Released

REVOCATION SECTION

I do hereby request that the authorization to disclose health information of ______________________________
(Name of Client)

signed by ______________________________ on ______________________________
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective ____________________. I understand that any action taken on this authorization prior to the rescinded date
(Date)

is legal and binding.

______________________________	____________	______________________________	____________
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

______________________________	____________	______________________________
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by ______________________________
(Name of Client or Personal Representative)

on ____________________. The client or his personal representative has been informed that any action taken on this
(Date)

authorization prior to the rescinded date is legal and binding.

______________________________	____________
(Signature of Staff)	*(Date)*

______________________________	____________
(Signature of Witness)	*(Date)*