WAKE
PSYCHIATRY

DISCLOSURE AND CONSENT FORM

Patient Name_____

☐ I DO want my health information shared as specified below. This authorization will expire in two years from today. I have the right to revoke this authorization at any time by stating this in writing and sending my written revocation to Wake Psychiatry PLLC.

I authorize Wake Psychiatry PLLC to release protected health information to the entities below:

1. Give Information to spouse/partner

Name: _____

Description of Information to be released:

☐ Financial/Billing

☐ Medical Information

2. Give information to a parent (if above 18), friend or family member, please list:

Name _____ Relationship to Patient_____

Description of Information to be released:

☐ Financial/Billing

☐ Medical Information

OR

☐ I DO NOT want my health information to be shared with anyone other than my insurance company. My refusal will not affect my ability to obtain healthcare treatment, payment or eligibility for benefits.

Signature _____ Date_____