1500 Sunday Drive   Ste. 200

Raleigh, NC 27607

P: 919.322.2413   F: 919.322.2416

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient:____ DOB:__________ SS#:______________

Information to be released to / from:	Information to be released to / from:
____________________, M.D.	Name/Agency:____________________
Wake Psychiatry, PLLC	Address:________________________
1500 Sunday Dr. Ste. 200	______________________________
Raleigh, NC 27607	P:_____________ F:_____________

Please provide current phone number in the event we need to reach you:___________________

Purpose of Release:

( ) Legal Representation   ( ) Disability Determination   ( ) Insurance

( ) Request of individual   ( ) Continuity of care / verbal communication

Information to be released:

( ) Date of hospitalization   ( ) Psychiatric evaluation   ( ) Psychosocial assessment   ( ) Discharge summary

( ) Psychological evaluation   ( ) Progress notes   ( ) Medication reports( ) History & physical exam   ( ) Lab / x-ray reports

( ) Consultation reports   ( ) Progress update / verbal   ( )Other:_______________________

I understand that I may revoke or terminate this authorization at any time by submitting a written revocation to Wake Psychiatry, PLLC, except to the extent that action has already been taken in reliance there on. If not previously revoked, this authorization will expire in 6 months from the date of signature. I hereby give permission to release the information above which may include information regarding drug/alcohol abuse, treatment, and psychological or psychiatric impairments, HIV and/or AIDS or physical conditions.

I understand that the person or organization to which it is sent may disclose information that is disclosed under this authorization again. The privacy of this information may not be protected under the federal privacy regulations.

I understand that I may inspect or request a copy of information (for a fee) that is used or disclosed under the authorization and I may refuse to sign this authorization.

Signature of patient____________________________________ Date:_____________

Signature of staff_____________________________________ Date:_____________