5509-B W. Friendly Avenue, Suite 106, Greensboro, NC 27410 • 1777 Fordham Blvd., Suite 202-1, Chapel Hill, NC 27514

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

This form, when completed and signed by you, authorizes the release of protected health information from your clinical record to and/or from the person you designate. It cannot be used to re-release confidential information by other individuals or facilities. Such requests should be referred to the original individual or facility.

RE: ______________________________ DOB: ______________________

I ____________________________ authorize Carolina Psychological Associates, P.A. to:

[ ] Disclose information to [ ] Obtain information from [ ] Exchange information with

Person/Facility: ____

Address: ______________________________ Telephone: ________________

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The information to be disclosed is:
[ ] Treatment summary
[ ] Psychiatric evaluation/medication history
[ ] Psychological evaluation results
[ ] Medical history and evaluation(s)
[ ] Educational records

The purpose of this disclosure is for:
[ ] Coordination of care
[ ] Further evaluation/assessment/treatment
[ ] Treatment planning
[ ] Other (specify) ________________
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This consent is effective on ________________ and expires on ________________

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is completely voluntary on my part and will expire automatically after one year from the date on which it is signed. I have the right to revoke authorization, in writing, any time, except to the extent that action based on this consent has already been taken or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Client/Parent/Guardian Signature: ____________________________ Date: __________

Clinician Name: ____________________________