CAROLINA PSYCHOLOGICAL ASSOCIATES

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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: _____

_____

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

The purpose of this disclosure is for:
[ ] Coordination of care
[ ] Further evaluation/assessment/treatment
[ ] Treatment planning
[ ] Other (specify) _____

_____

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: _____