North Raleigh Mental Health and Wellness
920-D Paverstone Drive
Raleigh, NC 27615
Phone: (919) 896-6998 Fax: (866) 610-4552

Authorization to Obtain or Release Protected Health Information

_____ _____ _____-_____-_____
Patient Name (please print) Date of Birth Social Security Number

I hereby freely and voluntarily authorize North Raleigh Mental Health to:
☐ Release/disclose my protected health information
☐ Obtain my protected health information

Individual, Facility, or Organization Name: _____
Street: _____
City, State, Zip: _____
Phone: (_____)_____ Fax: (_____)_____

The purpose of this authorization is for:
☐ Continued treatment ☐ Progress Updates ☐ Legal reasons
☐ Discharge planning ☐ Insurance Purposes ☐ Medical treatment
☐ Other (explain): _____

Information to be obtained or disclosed:
☐ Psychiatric evaluation ☐ Lab/X-ray results
☐ History & Physical ☐ Progress Report (verbal)
☐ Medication records ☐ Physician's Orders ☐ All records
☐ Aftercare Plan ☐ Discharge summary ☐ Other (explain)
_____

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to North Raleigh Mental Health's Privacy Officer, except to the extent that action has already been taken in reliance on it.
This authorization will expire in 12 months following the signing of the form, unless another date or condition is specified.
Other date or condition specified: _____

_____ _____
Patient Signature Date

_____ _____ _____
Guardian or Legal Representative Signature Date Relationship to patient

_____ _____
Witness Signature Date