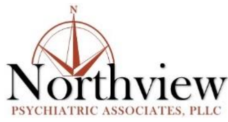

8360 Six Forks Road, Suite 103, Raleigh, NC 27615 | p 919.689.4921 | f 919.289.1412 | www.northviewpsych.com

Authorization to Use or Disclose Protected Health Information

Patient Name: ____ **Date of Birth (*mm/dd/yyyy)***: ________________
(Print Name)

I authorize Kimberly Bennett, MD to obtain and/or release medical records from/to:

Name:____ **Phone #**:__________________________

Address:____ **Fax #**:____________________________

City, State, Zip:____

Dates of Treatment:____

Purpose of the Release (*check all that apply*):

_____ Coordination/Continuity of Care
_____ Legal
_____ Payment
_____ Insurance
_____ Patient's Request
_____ Referral
_____ Other (*Please specify*_________________________)

Information to be Released (*check all that apply*):

_____ Assessments
_____ Psychiatric Evaluations
_____ Psychological Evaluations
_____ Admission Note/Discharge Summary
_____ History and Physical
_____ Financial
_____ Labs/Imaging/Medical Tests and Procedures
_____ Medication Records
_____ Medical History
_____ Progress Notes
_____ Psychotherapy Notes
_____ HIV/AIDS Information
_____ Substance Abuse/Treatment
_____ Other (*Please specify*_________________________)

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information (45 CFR, Parts 160, 164; 42 CFR, Part 2; G.S. 122 C). I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this authorization will expire one year from the date of signature unless I designate and alternate date. I acknowledge that the released information may contain sensitive material, such as, but not limited to, information relating to HIV status, drug or alcohol abuse, and/or psychiatric or psychological function. I understand that information disclosed under this authorization may be disclosed again by the recipient of this information after which 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 that is used or disclosed under this authorization. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.

____ ____
Signature of Patient Date Witness Date

____ ____
Signature of Legally Responsible Person Date Relationship to Patient