RECORDS RELEASE OF INFORMATION
PATIENT AUTHORIZATION FOR USE AND
DISCLOSURE OF HEALTH INFORMATION

TO____

DOCTOR OR HOSPITAL

____

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

□ **TWO WAY EXCHANGE OF INFORMATION**

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS

AND/OR TREATMENT DURING THE PERIOD FROM ________________ TO ______________

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on __________________________. I do not have to {Expiration Date or Defined Event} sign this authorization in order to receive treatment from Raleigh Psychiatric Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Office at 3900 Browning Place, Suite 201, Raleigh, North Carolina 27609.

NAME ________________________ DATE OF BIRTH________________ DATE_____________

ADDRESS____

SIGNATURE________________________________ WITNESS_____________________________

(IF RELATIVE, STATE RELATIONSHIP)