CAROLINA CENTRE

BEHAVIORAL HEALTH

THE CAROLINA PSYCHOLOGICAL GROUP, P.A. DBA CAROLINA CENTRE
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ADULT, ADOLESCENT AND CHILD SERVICES
FAMILY AND MARITAL COUNSELING
PSYCHOLOGICAL TESTING AND ASSESSMENTS
ADDICTIVE TREATMENT SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____

_____

Social Security Number: _____

"I hereby authorize this practice to _____Release _____ Obtain, and/or _____ Exchange my protected health information as indicated below."

This information is to be released from:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

This information is to be disclosed to:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Description of information to be disclosed/exchanged:

Reason for requested use or disclosure:

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

- ✓ This is a legal document and will not be honored unless completed in full. A true and accurate photocopy shall be considered as valid as the original for release of information.
- ✓ I may revoke this authorization at any time by providing written notice to the practice.
- ✓ The practice will not condition treatment based on my signing of this authorization.
- ✓ I am signing this authorization freely without pressure from anyone.
- ✓ The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer subject to federal law.
- ✓ I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
- ✓ I have been offered a copy of this authorization.

Patient Signature: _____

Signature of Patient Representative: _____ Date: _____

Relationship: _____

Witness: _____ Date: _____

FOR OFICE USE ONLY:

Date or event upon which authorization will expire: _____