

Authorization for use and disclosure of protected information

Use this to request that outside providers communicate with the Mood Treatment Center.

Today's date: \_\_\_\_\_

1) Enter the patient's information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I, the above named patient, request the health care provider below (enter the name of the place you'd like records sent from):

Provider or facility: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

To release the following information:

<input type="checkbox"/> Psychiatric Records	<input type="checkbox"/> Medical Records
<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Diagnostic & Laboratory Testing
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Conversation
<input type="checkbox"/> Records of Psychiatric Hospitalization	<input type="checkbox"/> Other _____

Regarding services rendered during the following dates: \_\_\_\_\_

TO: Mood Treatment Center, Mailing: 1615 Polo Rd, Winston-Salem NC 27106

Fax: (336) 201-0538, Phone: (336) 722-7266

The purpose of this disclosure is:

Treatment  Legal  Disability  Family involvement

Other: \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the treatment facility or clinician named above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

I understand that this authorization for disclosure is voluntary and that I need not sign this form to ensure healthcare treatment.

This authorization will expire on \_\_\_\_\_ (if blank it expires 12 months from the date signed)

Signature of patient: \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent/guardian if under 18: \_\_\_\_\_ Date \_\_\_\_\_