

1615 Polo Road  
Winston-Salem, NC 27106

**Mood Treatment Center**  
www.moodtreatmentcenter.com

PHONE: (336) 722-7266  
FAX: (336) 201-0538

### Authorization for use and disclosure of protected information

I, \_\_\_\_\_ ,

Date of birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

Authorize:

Name of treatment facility or clinician \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

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"/> Other _____
<input type="checkbox"/> Records of Psychiatric Hospitalization	<input type="checkbox"/> Other _____

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

To: Dr. Chris Aiken, Mood Treatment Center, 1615 Polo Road; Winston-Salem, NC 27106.  
Fax: (336) 201-0538

The purpose of this disclosure is for treatment and continuity of care.

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 no date is entered it will expire in 12 months from the date signed).

Signed: \_\_\_\_\_ Date \_\_\_\_\_