Authorization for use and disclosure of protected information

Use this to request that the Mood Treatment Center release records to outside providers or communicate with other people in your life.

Today's date: _____

1) Enter the patient's information:

Name: _____ DOB: _____

Address: _____

Phone: _____

I, the above named patient, request the Mood Treatment Center communicates with:

Person, provider or facility: _____

City: _____ State: _____

To release the following information:

___ Psychiatric Records
___ Substance Abuse Treatment
___ Psychological Testing
___ Records of Psychiatric Hospitalization
___ Medical Records
___ Diagnostic & Laboratory Testing
___ Conversation
___ Other _____

Regarding services rendered during the following dates: _____

The purpose of this disclosure is:

___ Treatment ___ Legal ___ Disability ___ Family involvement

Other: _____

TO: Mood Treatment Center, Mailing: 1615 Polo Rd, Winston-Salem NC 27106
Fax: (336) 201-0538, Phone: (336) 722-7266

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 _____