Porters Neck Counseling
8044 Market Street Unit D Wilmington, NC Phone: 910.686.3505 Fax: 1.866.941.4943

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

This form when completed and signed by you, authorizes the mutual exchange of protected information from the clinical record of (patient name) _____ to the person you designate.

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security#: _____

I authorize Porters Neck Counseling and my Provider, _____ (8044 Market Street Unit D, Wilmington, NC 28411, 910-686-3505) and/or his or her administrative and clinical staff to exchange the following:

_____ Full Clinical Health Information Record
_____ Test Data Only (Name Tests) _____
_____ Information Specifically Named: _____

This information should only be exchanged with (name and address of person to whom the information is to be exchanged):

Name: _____
Address: _____
_____
Phone: _____ Fax: _____

I am requesting this exchange for the following reasons: ("at the request of the individual" is all that is required if you are the patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect for _____ or until _____
(mo., year, etc.): (mo., year, etc.):

I have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address. However, my revocation will not be effective to the extent that my provider has already taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my provider generally may not condition mental health services upon my signing an authorization unless the mental health services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature Date

_____ _____
(Print name of signer) (Relationship to Patient)

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

(Photocopies of this form are acceptable)