106 Third Avenue, NE
Hickory, NC 28601
(828) 322-9130
(828) 322-7890 FAX

Authorization to Obtain and/or Release Information

Patient Name_____ **Date of Birth**_____

I authorize the release or disclosure of the above named individual's health information as described below:

_____**OBTAIN** from the following individual(s) or organization(s)_____

_____**RELEASE** to the following individual(s) or organization(s)_____

The type of information to be obtained or released is as follows: **(check appropriate info)**

_____Entire record
_____Psychiatric and medical history, including diagnosis
_____Outpatient treatment, including progress notes
_____Past hospitalizations
_____Psychological testing
_____School records
_____All pertinent information relating to alcohol and/or drug abuse
_____Communicate as needed
_____Other (please describe)_____

I understand that I have the 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 above address. However, your revocation will not be effective to the extent that we have taken in reliance on the authorization.
I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
The authorization will expire:_____

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship

_____ _____
Witness Date