Patricia M. Brown M..A.
5010 Randall Parkway
Wilmington, NC 28403

Phone: 910-791-5719
Fax: 910-799-8180

Authorization Form

Client: _____ Date of Birth: _____

Name/Address of Agency, Organization or Individual Releasing/Receiving information

Patricia M. Brown M. A.
5010 Randall Parkway
Wilmington, NC 28403
Ph: (910) 791-5719 Fax: (910) 799-8180

Name/Address of Agency, Organization or Individual Releasing/Receiving information

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

This form when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate.

I authorize the above referenced individual, agency or organization and/or his or her administrative and clinical staff to release:

___ Admission H & P's
___ Psychiatric Records
___ Medical Records
___ Other: _____
_____

___ Psychological Records
___ Psychotherapy Records
___ Counseling Records
___ School Records (see letter)

___ Discharge Summaries
___ Psychiatric Assessments
___ Psychological Assessments/testing/reports
___ Psychosocial Evaluations
___ Educational Evaluations

__ I am requesting the above records be sent to Ms. Brown to assist my treatment or in my child's treatment.

__ I am requesting Ms. Brown release my records/my child's records for the purpose of assisting in my treatment or my child's treatment.

__ I give permission for Ms. Brown to exchange information with the above named person, agency, or organization.

This authorization will remain in effect for one year from the date signed or until (fill in an event that relates to the individual or the purpose of the use or disclosure). _____
_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have 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 practitioner generally may not condition services upon my signing an authorization unless the 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 your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client or Authorized Representative Date

_____ _____
Signature of Witness Date

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