TRIAD PSYCHIATRIC AND COUNSELING CENTER, P.A.

603 Dolley Madison Road Ste. 100
Greensboro, NC 27410
TELEPHONE (336) 632-3505
FAX (336) 632-3503

CONSENT FOR RELEASE OF INFORMATION

PATIENT:_____

DOB: _____

SSN: _____

This authorization form implements the requirements for consumer authorization to use amd disclose Health Information protected by the Federal Privacy Law (HIPAA) 45 CFR 160-16, the Federal Confidentiality Law 42 CFR (ii), and the State Confidentialty Law governing Mental Health, Developmental Disabilities, and Substance Abuse Services GS 122 C

I do hereby authorize Triad Psychiatric and Counseling Center, PA ____ release to / ____ request from (Doctor/Facility) : _____

____ Entire Record ____ Medications List ____Progress Note(s) dated: _____

____ Initial Evaluation ____ Labs ____ Other (specify): _____

____ I do ___ I do not authorize release of information related to HIV or substance and/or alcohol abuse.

For the purpose of:

____Continuity of Care ____ Transfer of Care ____ Other (specify) _____

This consent is given freely and voluntarily. Any information obtained shall not be release by the above named persons or agencies to any other persons or organizations unless I so authorize, except as mandated by state or federal law. In the event that information is released by a third party to unauthorized persons, the undersigned hereby releases Triad Psychiatric and Counseling Center, PA from any and all liability for such except to the extent that action has been taken in reliance thereon. This consent will expire without expressed revocation one year after I have signed this authorization or upon written revocation of consent.

Patient Signature _____

OR

Guardian Signature_____ DATE: _____

Witness Signature _____ DATE: _____