CONSENT FOR RELEASE OF CLIENT INFORMATION

Client Name: ______________________ DOB:_____________S.S._____-____-_____ Chart #: ______

Email:____

I hereby authorize **MindPath Care Centers at Carolina Partners in Mental HealthCare, PLLC** to…

☐ **release** ☐ **obtain**

specified information in my medical/client/educational record for the purpose of continued mental health care.

____
(Individual, Facility, or Organization)

____
(Address)

____________________________________ ____________________________________
(Phone Number) (Fax Number)

This data shall include the available items checked below:

- ☐ All Records
- ☐ Telephone Communication Only
- ☐ Admission Summary
- ☐ Progress/Treatment Notes
- ☐ Initial Evaluation
- ☐ Medication Log
- ☐ Discharge Summary
- ☐ Laboratory Results
- ☐ Psychological Testing
- ☐ Educational Testing
- ☐ Billing Records
- ☐ Other____________________________

Dates of Treatment:

From: To:

Disclosure and/or exchange of the protected health and account information as authorized above may include communication by phone, fax or mail. This disclosure and/or exchange may include information regarding drug, alcohol or sexual abuse, psychological or psychiatric impairments, HIV and/or AIDS or other physical conditions. If the authorized individual or entity that receives or releases this information is not a health insurance plan or health care provider covered by federal privacy regulations (HIPAA), the released information may be re-disclosed at will by the recipient or sender without the consent of the patient or guarantor and may no longer be protected by federal or state law. *If I refuse to sign this form, I understand that it will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or eligibility for health benefits.* Unless otherwise revoked in writing, this authorization will automatically expire one year from the date signed.

☐ Diagnosis of a Substance use disorder.

I have read and understood the above statements and I consent to the release of the protected health and account information as indicated above. I also understand that there may be costs incurred with this request. Any such costs will be in compliance with State copying laws.

____________________________________ ____________________________________
Client (or Guardian's) Signature Witness

____
Date