Anchor Psychological & Counseling Services, PLLC

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Client Name:_____ Chart #:_____ DOB:_____ DATE:_____

PURPOSE OF RELEASE:

Further mental health care | Payment of insurance claim | Legal investigation | Coordination of Care
Applying for insurance | Disability determination | At the request of the individual
Other (specify): _____

MUTUAL EXCHANGE OF INFORMATION

Anchor Psychological and Counseling Services, PLLC
16581 Highway 17, Suite 600
Hampstead, NC 28443
Phone: (910) 270-9995 Fax: (910) 270-9905

AND

Mr/Ms/Dr. _____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

INITIAL appropriate information to be released (Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.):

_____My Entire Mental Health Record including Substance Abuse
_____Verbal Communication
_____Only Those Portions pertaining to:_____
(Specific Provider name and/or dates of treatment)
_____Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
_____**I Decline**

NOTICE OF RIGHTS AND OTHER INFORMATION

Complete your acknowledgement that you understand that:

- You have the right to review the information that is being used or disclosed
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws
- You have a right to revoke this authorization at any time
- You have a right to receive a copy of this signed authorization.

Notice: *This information has been disclosed to you from records protected by the Federal Confidentiality Rules (42 CFR, Part 2). The Federal rules prohibit your from making any further disclosure of this information unless, further disclosure is expressly authorization for the release of the medical or other information is NOT sufficient for this purpose. The Federal Rules Restrict any use of the information of criminally investigates or prosecute any alcohol or drug abuse patient.*

Date of Authorization: ___/___/_____ Authorization to expire on ___/___/_____
Note: Authorizations are valid for a maximum of one year.

Patient Signature: _____ **Date:**_____ **Time:**_____

Signature Guardian/Parent/Authorized Representative: _____
If signed by a personal representative:
(A) Print your name: _____
(B) Indicate your relationship to the client and/or reason and legal authority for signing:
Patient is: Minor Incompetent Disabled Deceased
Legal authority: Parent Legal Guardian Representative of Deceased