Kaur Psychiatrics Associates, PA
3300 Battleground Ave #100 Greensboro, NC 27410
Phone: 336-645-9555 Fax: 336-282-0907

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

MENTAL HEALTH AND/OR SUBSTANCE ABUSE

Patient Information

Name: _____

Date of Birth: _____

Last 4 of Social: _____

Entity Information

_____
Name or Title of Person or Organization RELEASING information

_____
Name or Title of Person or Organization - RECEIVING information

Initial the items you would like to be released:

_____ Psychiatric Evaluation _____ All Records

Dates of Service to be Released: _____

_____ Progress Notes _____ Other

_____ Lab Reports _____

I understand that my records are protected under the Federal and State Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in regulations. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. I also understand that I may revoke this consent (in writing) at any time unless action has already been taken based upon it.

This information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS), as well as any drug / alcohol related data. I understand that this consent is valid for (1) year from the date signed and that I can revoke it at any time. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own

Signature of Client or Authorized Representative: _____ Date: _____

Signature of Witness: _____

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will <u>not</u> affect any action Kaur Psychiatric Associates, PA took in reliance on this authorization before receipt of this cancelation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: _____

***If records are greater than 25 pages, please <u>MAIL</u>, do not fax - Thank you!**