Authorization for use and disclosure of protected information

What's this for?

To ask your healthcare provider to send records or communicate with the Mood Treatment Center.

❶ Patient information

Name: _____ DOB: _____ Phone: _____

Address: _____

❷ Who you'd like to send records to us, and what you want them to send

I (the above named patient) request that the health care provider below:

Person, provider or facility: _____

City: _____ State: _____

Release the following information:

___ Psychiatric Records
___ Substance Abuse Treatment
___ Psychological Testing
___ Records of Psychiatric Hospitalization
___ Medical Records
___ Diagnostic & Laboratory Testing
___ Conversation
___ Other _____

Regarding services rendered during the following dates: _____

To: Mood Treatment Center, 713 SW Marshall St, Winston-Salem, NC 27101-5808
Fax: (336) 201-0538 Phone: (336) 722-7266

The purpose of this disclosure is:

___ Treatment ___ Legal ___ Disability ___ Family involvement

Other: _____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the health care provider named above. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that this authorization for disclosure is voluntary and that I need not sign this form to ensure healthcare treatment.

❸ Signature and expiration

This authorization will expire on _____ (if blank it expires 12 months from the date signed)

Signature of patient: _____ Date_____

Signature of parent/guardian if under 18: _____ Date _____