1615 Polo Road
Winston-Salem, NC 27106

Mood Treatment Center
www.moodtreatmentcenter.com

PHONE: (336) 722-7266
FAX: (336) 201-0538

Authorization for use and disclosure of protected information

I, _____,

Date of birth: _____ Social Security Number _____

Address _____

_____

Phone _____

Authorize: The Mood Treatment Center and Dr. Aiken, 1615 Polo Road; Winston-Salem, NC 27106.

To release the following information:

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

Regarding services rendered during the following dates: _____

To:
Name of treatment facility or clinician _____

Address: _____

City _____ State _____ Phone _____

The purpose of this disclosure is for treatment and continuity of care.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the treatment facility or clinician 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 the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

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

This authorization will expire on _____ (if no date is entered it will expire in 12 months from the date signed).

Signed: _____ Date _____