Holistic Mental Health, PLLC
800 W. Williams St
Suite 231A
Apex, NC 27502
Phone: (919) 267-9813
Fax: (919) 267-9814

Authorization to Release Protected Health Information

Patient Information:

Name of Patient:_____
Street Address:_____ City:_____ State:____ Zip:_____
Telephone Number:_____ Birthday:_____ SS#:_____

Please Check the Appropriate Type of Release of Information:

I, _____ agree to release my health information as indicated below in an ongoing exchange between Holistic Mental Health and _____ at_____
(Name) (Address)
_____, _____, _____.
(Address Continued) (Phone) (Fax)

I, _____ agree to release my health information as indicated below (Circle: with, from, to) Holistic Mental Health (Circle: and, to, from) _____ at _____
(Name) (Address)
_____,_____, _____.
(Address Continued) (Phone) (Fax)

Reason for Release of Information:
□ Continuing Medical Care
□ Patient's Request
□ Claim for Reimbursement
□ Other (specify):_____

Information to be Released:
□ Intake (History & Physical Exam
□ Discharge Summary
□ Psychological Testing
□ Radiological Studies
□ Laboratory Reports
□ Last Progress Note
□ Other (specify):_____
□ Entire Chart to include: Mental Health _____, Drug & Alcohol Use and Treatment: _____, Communicable Diseases (to include HIV/AIDS) _____.

Authorization:

I understand that refusal to sign this release of information does not prevent me from receiving care from Holistic Mental Health, PLLC, but that my refusal may negatively impact my overall health if necessary information from different treatment providers is unable to be exchanged.
I understand that this authorization can be revoked at any time, either orally or in writing.
I understand that this authorization will expire in two years from the date indicated below unless otherwise specified here: _____.

Patient Signature: _____ Date: _____
(or Parent, if patient is a minor)

Witness Signature: _____ Date: _____