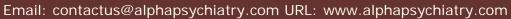
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

401 Keisler Dr. Suite 100 Cary, NC 27518; 6224 Fayetteville Rd Ste 105 Durham, NC 27713 Ph: 919-439-6120 Fax: 919-246-4420





Name	Date of Birth	SSN	
Street address	City	State	Zip
Lam requesting records to be s	ont to Alpha Devehiatric As	sociatos DLLC (Cary NC
I am requesting records to be sent to Alpha Psychiatric Associates PLLC, Cary NC. I am requesting Alpha Psychiatric Associates to send records to another provider.			
I authorize the person/organization noted below to release/receive the information/records specified below to/from Alpha Psychiatric Associates. This is being requested for the purpose of ongoing treatment.			
Person/Organization name			
Street	City	State	Zip
Phone:	Fax:		
The specific protected health information I am requesting to be disclosed is:			
Progress/Treatment Notes	Admission History & Physical		
Substance Abuse Records	Laboratory Results		
Psychological Testing	Diagnostic Imaging/Reports		
Other			
I understand that information or records sent to Alpha Psychiatric Associates may be incorporated into my medical record and will become part of my protected health information at Alpha Psychiatric Associates. This authorization will expire in 90 days from the date indicated below (or sooner if I revoke this in writing). I understand that I am not required to sign this form to receive care from Alpha Psychiatric Associates.			
To be filled when someone other than the patient signs: I hereby certify that I am the duly authorized representative of the above patient and authorized to sign this request on behalf of the above patient.			
Print your name:			
Signature (Patient /Representative)		Date:	
Relationship to Patient			