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
Email: contactus@alphapsychiatry.com URL: www.alphapsychiatry.com

Name | Date of Birth | SSN

Street address | City | State | Zip

☐ **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

© Alpha Psychiatric Associates PLLC 2016