WAYNESBORO FAMILY CLINIC, P.A.

Behavioral Medicine - Family Psychotherapy

1706 WAYNE MEMORIAL DRIVE • GOLDSBORO, N.C. 27534-2240 • (919) 734-6676

Authorization for Release of Client Health Care Information

Client Name: ______________________________

Date of Birth: ______________

Information Released To:
Agency: ______________________________
Address: ______________________________
____
Phone: ______________________________
Fax: ______________________________
Contact Person: ______________________________

Information Released From:
Agency: WAYNESBORO FAMILY CLINIC, P.A.
Address: 1706 Wayne Memorial Dr
Goldsboro, NC. 27534
Phone: 919-734-6676
Fax: 919-734-9050
Contact Person: Dr. Steve Hannant

Reason for Disclosure:
- ☐ Personal records
- ☐ Disability claim
- ☐ Provider transfer
- ☐ School request
- ☐ Other: ______________________________

Specific Information to be disclosed:
- ☐ Therapy records
- ☐ Medication records
- ☐ Evaluations / treatment summaries
- ☐ Psychological testing
- ☐ Other: ______________________________

Ii hereby authorize the release and/or exchange of the above identifying information from my records. I hereby release WAYNESBORO FAMILY CLINIC, P.A. from all legal responsibility or liability that may arise from this authorization. I understand that I have the right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless WAYNESBORO FAMILY CLINIC, P.A. has taken reliance upon it. And, I also understand that such revocation must be in writing and received by the provider to be effective. Therapist shall not condition treatment/services upon client signing this authorization and client has the right to refuse to sign this form. Client understands the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule.

This authorization shall remain valid for one year from the date of signature or until: ________________

______________________________Signature of Client/Guardian ______________Date

______________________________Witness ______________Date

Revocation of Consent:
I revoke the authorization as stated and as such no further information will be released

______________________________Signature of Client/Guardian ______________Date

______________________________Witness ______________Date