TRUE Mental Health & Wellness, PLLC
Trust. Rapport. Understanding. Encouragement.
15 Dawn Road, Suite 2, Pinehurst, NC 28374 | O:910-585-6108 F:910-475-1666 |
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AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Patient Name:_____ DOB:_____

I authorize TRUE Mental Health & Wellness PLLC to disclose/obtain the following information with the following:

_____
Name and Title of Person or Agency Receiving/Obtaining Information

_____
Address Including Zip Code

_____
Telephone/Fax Number

Check each box you authorize disclosing/obtaining of which information:

☐ Identifying Information	☐ Consultations
☐ Admission Registration	☐ Treatment Plan
☐ Diagnosis, Date of Service	☐ Progress Notes
☐ General Progress/Condition	☐ Psychiatric Consultation
☐ History and Physical	☐ Psychological Evaluation/ Assessments
☐ Mental Health Information	☐ Academic Information
☐ Substance Use Information	☐ Discharge Summary
☐ Laboratory Reports	☐ Other: (Please Specify):
☐ Doctor's Orders	

The purpose or need for the exchange and/or disclosure of this information is to:
☐ Facilitate Treatment
☐ Summarize Treatment
☐ Coordinate Continuing Care
☐ Other

If Other, please state purpose clearly:_____

PLEASE READ THE FOLLOWING CAREFULLY:

I, (Print Patient Name) _____, understand that this authorization will expire on the following date, event or condition. (Specify date) _____.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and may request a Revocation Form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if information contains information regarding substance use, it is protected by the Federal Substance Abuse Confidentiality Regulations and the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g. insurance company) for the sole purpose of creating health information (e.g. physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____

Signature of Patient OR Authorized Representative of Patient Date

If signed by Authorized Representative of Patient, please complete:
Printed Name of Representative:_____
Relationship to Patient:_____

***NOTE*: This Authorization was REVOKED on:_____
Staff Signature:_____