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Authorization for use and disclosure of protected information

I, _____ ,
Date of birth: _____ Social Security Number _____
Address _____

Phone _____

Authorize: Dr. Robin Stone; 13123 Rosedale Hill Ave., Huntersville, NC 28078

To release the following information:

- Psychiatric Records
- Substance Abuse Treatment
- Psychological Testing
- Records of Psychiatric Hospitalization
- Medical Records
- Diagnostic & Laboratory Testing
- Other _____
- Other _____

Regarding services rendered during the following dates: _____

To:

Name of treatment facility or clinician _____

Address: _____

City _____ State _____ Phone _____

The purpose of this disclosure is for treatment and continuity of care.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the treatment facility or clinician named above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

I understand that this authorization for disclosure is voluntary and that I need not sign this form to ensure healthcare treatment.

This authorization will expire on _____ (if no date is entered it will expire in 12 months from the date signed).

Signed: _____ Date _____

Witness: _____ Date _____