Prism Psychological Services, PC
10130 Perimeter Pkwy. - Suite 200
Charlotte, NC 28216
Phone/Fax: 704-212-2020

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ _____
(Print Full Name of Patient) (Date of Birth)
hereby authorize the release of my health information

between:

Practitioner or therapist name: _____
Prism Psychological Services, PC
10130 Perimeter Pkwy. - Suite 200
Charlotte, NC 28216

and:

Name: _____

Address: _____

City, State, Zip: _____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure: **Further mental health or medical care____ Letter____**
(check all that apply) **Legal investigation ____ Insurance request___**
Other:_____
Information requested: **Copies of records (progress notes, test reports), verbal information, letter, proof of attendance, or other:_____**

I give my permission for the information listed above to be exchanged between the above-named individuals or organizations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire one year after the date signed. The above-named individuals or organizations should not redisclose my medical record to another party without further written consent.

I will not hold above-named individuals or organizations nor Prism Psychological Services, PC liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking above-named practitioner for clarification of the information therein.

Date: _____ Patient signature: _____

Date: _____ Personal representative (if applicable*): _____

*** If patient is a minor, incompetent, disabled, or deceased**