Charlotte
Integrative Psychiatry
Customized Treatment for Individualized Care

Dr Joy Ross
Board Certified Child, Adolescent and Adult Psychiatrist
4334 Yoruk Forest Lane
Charlotte, NC 28211

Authorization for Release or Exchange of Confidential Health Information

I, _____
(Patient) (Former Patient) (Parent of Patient) (Guardian of Patient)

Hereby authorize Dr. Ross, Charlotte Integrative Psychiatry 4334 Yoruk Forest Lane Charlotte, NC 28211 to:

___Disclose information to ___Obtain Information From ___Exchange Information with

_____ _____
Name Phone

_____ _____
Address Fax

_____
City, State, Zip

Regarding: _____
(Patient Name) (DOB) (SS#)

The information to be disclosed is:

____ Summary of Treatment/Lab Results

Other (Specify):

_____

_____

_____

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I understand that my medical and psychiatric records may be protected by federal regulations which may determine the extent and nature of the information which may be disclosed pursuant to this authorization. I do hereby give this consent to the release of the records described above freely and voluntarily, and acknowledge that I am not under any force or duress. I further understand that the provision of psychiatric or medical treatment and care will not be denied by reason of refusal to sign this consent form.

I understand that the policy of Charlotte Integrative Psychiatry is to release only that information about a patient or a former patient, in their judgment, is considered essential for the above purpose. The authorization does not obligate them to open their records for inspection, or to otherwise provide information which may violate the above policy. The information that has been disclosed to you is from records whose confidentiality is protected by federal law which prohibits you from making further disclosure of it without the specific written consent of the patient to whom it pertains.

This consent shall remain effective for the duration of treatment plus 90 days or for the purposes or periods indicated below. If no specific date, event, or condition is indicated, this consent will last no longer than reasonably necessary to serve the purpose for which it is given.

_____

(specify date, event, or condition upon which it will expire)

I understand that I may revoke (in writing) this consent at any time except to the extent that action based on this consent has already been taken.

Signed this _____ day of _____, 20_____.

_____

Signature of Patient **Signature of parent, guardian, or authorized representative**

_____

Present Address **Nature of Relationship**

_____

City, State, Zip **Present Address**

_____

Witness Signature **City, State, Zip**