3134 Wendell Blvd.
Wendell, NC 27591
919-374-7283
919-374-7285
journeysmhw@gmail.com
Www.journeysmhw.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____ DOB: _____ PHONE: _____

(TO BE FILLED OUT BY OFFICE PERSONNEL)

Select one of the following:

Journeys in Mental Health & Wellness to provide copies to:

_____

Journeys in Mental Health & Wellness to obtain copies from:

_____

Select one in each section:

A. REASON FOR REQUEST: ☐ **Continued Care** ☐ **Other**

_____

B.INFORMATION NEEDED - not all may apply, and fee may be charged

☐ COMPLETE MEDICAL RECORDS

☐ PROGRESS NOTES

☐ LAB WORK / TEST RESULTS

☐ OTHER: _____

C.DATE OF ENCOUNTER OR VISIT: _____ ☐ ALL DATES

D.HOW TO SHARE INFORMATION

☐ EMAIL: **journeysmhw@gmail.com**

☐ FAX Name: **Journeys in Mental Health & Wellness**

Fax number with area code: **919-374-7285**

I understand information to be disclosed may include information/results regarding psychological or psychiatric impairment, sexual assault, alcohol abuse, drug abuse, and/or a communicable disease including HIV/AIDS. I understand that I may revoke (cancel) this authorization at any time except to the extent that the information has already been released pursuant to federal health privacy law (42 C.F.R. Part 164) protecting health information (HIPAA). If I revoke this authorization, I must do so in writing to the Medical record Services Department. Unless otherwise revoked, this authorization will automatically expire 1 year after the date signed. I understand that treatment will not be conditioned upon my completion of this authorization. I understand that the information disclosed pursuant to this authorization may be subjective to re-disclosure by a recipient of such information and would no longer be protected under the terms of the federal privacy rule.

Copy Clause: I agree that a copy of this form may act as an original. I have the right to revoke this authorization in writing. The information released may be disclosed to other parties.

If not signed by patient: I, _____ hereby certify and attest that I am the duly authorized personal representative of the above patient, and that I have the lawful authority to enter into this authorization on behalf of such individual. I understand proof of this authority may be requested. I have read the provisions set forth in this authorization and agree that Journeys in Mental Health & Wellness may disclose the medical information of such individual for the purposes set forth.

Patient or Representative Full Name	Patient or Representative Signature	Date

Relationship to Patient: _____