



Patient Name _____

Date of Birth _____

THIS FORM MUST BE COMPLETED IN FULL

I authorize and request: NC-CCHD
1004 Dresser Court Suite 107
Raleigh, NC 27609
(919) 803-8128 office
(919) 876-3325 fax

to release to: _____

(Name of individual or organization PROVIDING/SENDING information)

(Address/Phone Number)

YES NO information concerning the history, treatments, examinations, and or hospitalization for the
period from _____ through _____

YES NO information pertinent to diagnosis and treatment of alcohol abuse, drug abuse,
HIV/AIDS, and psychiatric or psychological evaluation or treatment for the
period from _____ through _____

I understand that I may revoke this consent at any times except to the extent that action has already been taken on it.

NOTE: FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR IS OTHERWISE PERMITTED BY 42 CFR Part 2.

Signature of Patient

Date

Signature of Patient's Legal Representative (if applicable)

Relationship to Patient