

Katherine Peppers DNP, CPNP, CPMHS, PLLC
 3812 Rocking Robyn Run
 Knightdale, North Carolina 27585
 919-862-7633 - Phone
kp@katherinepeppers.com
 949-437-2099 - Fax

RELEASE OF INFORMATION

Name:	DOB
Parent/Guardian Name:	
Address:	
City	State
Zip Code	

Information Released From:	Information Released To:
Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone #:	Phone #:
Fax #:	Fax #:

Reciprocal Authorization for Release Information (Check if applicable)

_____ A reciprocal authorization allows Katherine Peppers DNP, PLLC to have continuous dialogue between the provider and staff of Katherine Peppers DNP, PLLC and the individual/group listed above.

Description of Information to be Released (Check if applicable)

_____ Complete Medical Record _____ Psycho-educational testing _____ Record of Psychiatric Hospitalization
 _____ Diagnostic/Lab Testing _____ Other (_____)

Regarding services rendered during the follow dates _____.

Purpose of Release of Record (check one)

_____ Continuing Treatment _____ Personal _____ Legal Involvement _____ Moving _____ Insurance
 _____ Other (_____)

Confidential information relative to aa patient with HIV infection or AIDS shall only be released in accordance with G.S. 130A-143.

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipients of that information. I specifically authorize any medical personnel of Katherine Peppers DNP, PLLC or any other individuals listed above to disclose my protected health information as described on this form to the recipients listed. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. This authorization shall be valid for one year from signature. I hereby release Katherine Peppers DNP, PLLC from all legal responsibility or liability that may arise from this authorization.

Patient/Legal Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

Katherine Peppers DNP, CPNP, CPMHS, PLLC
3812 Rocking Robyn Run
Knightdale, North Carolina 27585
919-862-7633 - Phone
kp@katherinepeppers.com
949-437-2099 - Fax