ZARZAR PSYCHIATRIC ASSOCIATES, PLLC
4301 Lake Boone Trail, Suite 210
Raleigh, NC 27607
Telephone (919) 278-2041
Fax (919)278-2042

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize ___________________________________ to release specified information in my patient record to **ZARZAR PSYCHIATRIC ASSOCIATES, PLLC.**

Dates of Treatment: ___________________________ (Please do not include entire chart unless specifically requested below)

This date shall include:

[ ] Discharge Summary
[ ] History and Physical
[ ] Consultation Reports
[ ] EKG's, MRI's, EEG's, X-Rays
[ ] Exchange of information/release of clinical information for coordination of care between above-named individuals (telephone and/or written communications).

[ ] Progress Notes
[ ] Lab Reports (Specify):______________
____
[ ] Other (Specify):
____
____

Purpose of Request:
[ ] Continued Treatment [ ] Other (Specify):__________________________

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that the contents may be subject to facsimile transmission. I acknowledge that the released information may contain sensitive material, such as, but not limited to, information relating to HIV status, drug or alcohol abuse, or psychiatric or psychological information. I have been informed and understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information, and at that point, the information may no longer be protected under the terms of this agreement. I further acknowledge that I may revoke this consent at any time, except to the extent that action has been taken. This written revocation of the Authorization must be submitted to:

____
Person authorized to release information as above

This Authorization will expire on:______________

____
Address
____
____

____________________________________ ____________________________________
Patient's Printed Name Date of Birth

____________________________________ ____________________________________
Signature of Patient or Legal Representative Date

____________________________________ ____________________________________
Witness Date