ZARZAR PSYCHIATRIC ASSOCIATES, PLLC
4301 Lake Boone Trail, Suite 210
Raleigh, NC 27607
Telephone (919) 278-2041
Fax (844)425-9215

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize **Zarzar Psychiatric Associates, PLLC** to release specified information in my patient record to _____.

Dates of Treatment: _____

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):_____

Delivery Method:
[ ] Faxed
[ ] Mailed

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:

Zarzar Psychiatric Associates, PLLC
4301 Lake Boone Trail, Suite 210
Raleigh, NC 27607

This Authorization will expire on:_____

_____ _____
Patient's Printed Name Date of Birth

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date