RELEASE FOR MEDICAL RECORDS/CLINICAL NOTES/LAB

►***Please sign this form with the name and address of any physician/counselor you may have seen that prescribe or have prescribed medications, taken labs or administered medical or therapeutic attention. This release is for the exchange of written records or verbal communications. One release per Physician/Counselor/Facility. Use this for Family/Individual as well.

Patient Name: _____, DOB: _____/_____/_____, SSN_____

This Patient authorizes this request between the following parties
TO AND FROM THE FOLLOWING LISTED FACILITIES

↻ JASON E. MASTOR, M.D.
↻ KRISTIN C. BROWN, PA-C, M.M.S.
206 Joe V. Knox Ave Ste F Mooresville, N.C. 28117 Ph: 704-662-6500 Fx: 704-662-6503

Provider Name:	Phone:	Fax:
_____	_____	_____
_____	_____	_____
_____	_____	_____

This is for the purpose of continuing care, the data shall include all Psychiatric Notes, Laboratory Reports along with any Medical and medicinal information needed for treatment. I also understand the information released may include drug/alcohol abuse, psychological or psychiatric impairments, and/or HIV/AIDS or any other medical findings. Once information is disclosed to the pursuant party signed on this authorization, I understand that the HIPPA privacy law (45 C.F.R. part 184) protecting health information may not apply to the recipient of the information, and, therefore may not prohibit the recipient from re-disclosing it. Other laws however may prohibit re-disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. part 2), this organization informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. This consent is valid for one year.

It has been explained to me and I understand the contents to be released/exchanged for written or verbal communication, I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further understand that I may refuse to sign or revoke this consent at any time except to the extent that action based on this consent has already been taken. Revocation should be presented to my treating clinician by written or verbal consent.

_____
Patient / Guardian Name **Date**

_____
Witness **Date**

OFFICE USE ONLY:
With this release, our office requests information checked below: ☐ Need no information, please file

☐LABWORK **☐INSURANCE INFORMATION**
☐OFFICE NOTES **☐PHONE CALL FROM PHYSICIAN**
☐MEDICATION LIST
OTHER_____

► ☐ ***Sending requested records to another facility*** ☐ **FOR VERBAL ONLY**

F=Faxed	Date: _____F/M/P	☐ Received
M=Mailed	Date: _____F/M/P	☐ Received
P=Picked-up	Date: _____F/M/P	☐ Received