

Robin Casey MD, PLLC

117 Hidden Valley Drive
Chapel Hill NC 27516
phone: 919-998-6463 fax: 844-433-3838
www.robincaseymd.com

Authorization to Obtain or Release Protected Health Information

Patient Name (please print)

Date of Birth

Last 4 digits of Social Security Number

I hereby freely and voluntarily authorize Robin Casey MD to:

- Release/disclose my protected health information
- Obtain my protected health information

Individual, Facility, or Organization Name: _____

Street: _____

City, State, Zip: _____

Phone: (____) _____ Fax: (____) _____

The purpose of this authorization is for:

<input type="checkbox"/> Continued treatment	<input type="checkbox"/> Progress Updates	<input type="checkbox"/> Legal reasons	
<input type="checkbox"/> Discharge planning	<input type="checkbox"/> Insurance Purposes	<input type="checkbox"/> Medical treatment	
<input type="checkbox"/> Other (explain): _____			

Information to be obtained or disclosed:

<input type="checkbox"/> Psychiatric evaluation	<input type="checkbox"/> Lab/X-ray results	<input type="checkbox"/> Therapy notes	
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Progress Report (verbal)		
<input type="checkbox"/> Medication records	<input type="checkbox"/> Physician's Orders	<input type="checkbox"/> All records	
<input type="checkbox"/> Aftercare Plan	<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Other (explain)	

*I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Robin Casey MD, PLLC's Privacy Officer, except to the extent that action has already been taken in reliance on it. **This authorization will expire in 12 months following the signing of the form, unless another date or condition is specified.***

Other date or condition specified: _____

Patient Signature

Date

Guardian or Legal Representative Signature
Relationship to patient _____

Date

Witness Signature

Date

