Type of Provider:

Robin Casey MD, PLLC

117 Hidden Valley Drive, Chapel Hill NC 27516
phone / fax: 844-345-2256
www.robincaseymd.com

Authorization to Obtain or Release Protected Health Information

_____ _____ _____
Patient Name (please print) Date of Birth Last 4 digits of Social Security No

I hereby freely and voluntarily authorize Robin Casey MD / Chatham North Psychiatry to:

- [x] Release/disclose my protected health information to the following
- [x] Obtain my protected health information from the following

Individual, Facility, or Organization Name: _____

Street: _____

City, State, Zip: _____

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

The purpose of this authorization is for:

[x] Continued treatment	[ ] Progress Updates	[ ] Legal reasons
[ ] Discharge planning	[ ] Insurance Purposes	[ ] Medical treatment
[ ] Other (explain): _____		

Information to be obtained or disclosed:

[ ] Psychiatric evaluation	[ ] Lab/X-ray results	[ ] Therapy notes
[ ] History & Physical	[ ] Progress Report (verbal)	
[ ] Medication records	[ ] Physician's Orders	[x] All records
[ ] Aftercare Plan	[ ] Discharge summary	[ ] 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 / Time

_____ _____
Guardian or Legal Representative Signature Date / Time

Relationship to patient _____

_____ _____
Witness Signature Date / Time