

# Lewis Associates

Consulting and Psychological Services

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www.drlewisassociates.com

919-302-8362

## AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_ voluntarily authorize Lewis Associates to:

\_\_\_\_\_ Release records/information concerning my mental and/or medical health to:

\_\_\_\_\_ Obtain records/information concerning my mental and/or medical health from:

Name, address, and phone number:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization shall be in effect for the time period of one year or: \_\_\_\_\_

The specific and relevant information I wish to have released is:

<input type="checkbox"/> dates of appointments	<input type="checkbox"/> diagnosis and/or focus of services
<input type="checkbox"/> summary of previous treatment	<input type="checkbox"/> discharge summary
<input type="checkbox"/> referral letter	<input type="checkbox"/> intake evaluation report
<input type="checkbox"/> psychiatric evaluation report	<input type="checkbox"/> psychological assessment report
<input type="checkbox"/> other (specify): _____	

I am requesting the release of this information for the following reasons:

at the request of the individual     coordination of care     coordination of health benefits

I understand the information to be released, the need for this information, and that it may include information regarding: drug abuse, alcohol abuse, psychological or psychiatric impairments, hiv/aids and physical conditions. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

This consent is completely voluntary. I understand that I may revoke consent at any time by written request, except to the extent that action based on this consent has been taken or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

\_\_\_\_\_  
printed name

\_\_\_\_\_  
signature of witness / date

### NOTICE TO ANY PARTY RECEIVING CONFIDENTIAL INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by federal and state law. Regulations may prohibit you from making further disclosure of this information without the prior written consent of the person to whom it pertains.