Consent for Release Form

Name *

Date of Birth (DOB) *

mm/dd/yyyy

I hereby authorize Gregory Narron M.D. And Associates , PLLC to

RELEASE OBTAIN VERBALLY

COMMUNICATE specified information in my medical/client/educational record for the purpose of continued mental health care.

(Individual, Facility, or Organization)

Address

City

State

Zip

Phone Number

(xxx) xxx-xxxx

Fax Number

(xxx) xxx-xxxx

This data shall include the available items checked below:

- [ ] Communication Only
- [ ] Discharge Summary
- [ ] Admission Summary
- [ ] Laboratory Results
- [ ] Progress/Treatment Notes
- [ ] Psychological Testing
- [ ] Initial Evaluation
- [ ] Educational Testing
- [ ] Medication Log
- [ ] Other

Disclosure and/or exchange of the protected health and account information as authorized above may include communication by phone, fax, or mail. This disclosure and/or exchange may include information regarding drug, alcohol or sexual abuse, psychological or psychiatric impairments, HIV and/or AIDS, or other physical conditions. If the authorized individual or entity that receives or releases this information is not a health insurance plan or health care provider covered by federal privacy regulations (HIPAA), the released information may be re-disclosed at will by the recipient or sender without the consent of the patient or guarantor and may no longer be protected by federal or state law. If I refuse to sign this form, I understand that it will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan, or eligibility for health benefits. NOTE: This consent does not expire; however, it may be revoked at any time IN WRITING, except to the extent that any action has already been taken prior to revocation. I have read and understood the above statements and I consent to the release of the protected health and account information as indicated above. I also understand that there may be costs incurred with this request. Any such costs will be in compliance with State copying laws.

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Patient / Guardian Signature *

Office Staff Witness

Date *

mm/dd/yyyy

Submit

Your information will be encrypted.