



# Gregory Narron M.D. And Associates, PLLC

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## CONSENT FOR RELEASE OF INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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)

\_\_\_\_\_  
(Phone Number) (Fax Number)

### 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.

\_\_\_\_\_  
**Patient (or Guardian's)**

\_\_\_\_\_  
**Office Staff Witness**

\_\_\_\_\_  
**Date**