Gregory Narron M.D. And Associates, PLLC

5 Kitchin Place Suite 220
Asheville, NC 28803
Phone 828.274.1415
Fax 828.274.9943

Gregory H. Narron, MD Jason Fredericks, PA-C, MPH
Rebekah MacNair, PMHNP-BC
Melissa Hall, PMHNP-BC
Robbie Hendon, LCMHC
Jesse Gronback, LCSW

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