AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ of _____
(Patient's Name) (Address)

_____
(City, state) (Zip code)

Patient's Date of Birth: _____ authorize: SILVER PSYCHIATRICS SERVICES/ Randie Schacter, DO
212 W Matthews St. # 106, Matthews, NC 28105, Phone 704-847-0424, Fax704-847-0454

To release/obtain my medical information to:

Organization and or Person: _____ Relationship to Patient: _____
Address: _____
Phone: _____ Fax: _____

I hereby authorize **Silver Psychiatric Services** to release/obtain copies of **Psychiatric Evaluation, Psychiatric Summary, Progress Notes, Psychotherapy Notes, Drug and Alcohol, HIV and Medical information**
Except for restrictions listed here _____
from the health care record pertaining to my hospitalization/treatment of _____ (Specify dates of treatment)

This information is being disclosed for the following purpose (s): (Check at least one)		
( ) Changing physicians	( ) Legal Purposes	( ) Insurance
( ) Continuing Care	( ) Social Security/Disability	( ) School
( ) At my (patient) request	( ) Workers Compensation	( ) Second Opinion

This authorization is valid as long as you are an active patient at Silver Psychiatric Services. I understand that this authorization is valid for the period of time needed to fulfill its purpose, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time in writing. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____ _____
Patient/Patient Representative Signature Date

Should you chose to **REFUSE/REVOKE PERMISSION** to release the above listed information, sign below

_____ _____
Patient/Patient Representative Signature Date

Legal Authority to sign for patient:	___ Guardian	___ Administrator/Executor	___ Parent		
___ Attorney in Fact	___ Next of Kin	___ Other (specify) _____			
Patient is:	___ Minor	___ Disabled	___ Deceased	___ Incompetent	___ Incapacitated

Updated 2/1/2020