Patient Label

CONSENT FOR RELEASE/DISCLOSURE OF RECORD CONTENT

PATIENT: ______________________________ **BIRTH DATE:** ______________

LOCATION: ☐ **ACUTE** – Expires in ninety (90) days, unless revoked or otherwise stated:____________

☐ **RESIDENTIAL** – Expires in one year, unless revoked or otherwise stated:____________

☐TO ☐FROM	**(Name/address/phone number with whom information is to be exchanged)**
BRYNN MARR HOSPITAL **192 Village Dr. Jacksonville, NC 28546 (910) 577-1400**	________________________________ ________________________________ ________________________________ ________________________________

I hereby request and authorize the above-named agency, organization or individual which possess information relative to the patient named above to release the following information unless specified as a restriction below to the agency, organization or individual named on this request. **I understand that the information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, or HIV diagnostic information.**

INFORMATION REQUESTED: (Please check approved items)

☐ Social History ☐ Discharge Summary ☐ Psychiatric Assessment ☐ Psychological Testing
☐ History & Physical ☐ Labs ☐ Other: ______________

PURPOSE OF NEED FOR WHICH INFORMATION IS TO BE USED:	☐ Obtain Social History Information ☐ Referral Source Follow-Up ☐ Insurance Verification ☐ Obtain Medically Necessary Information ☐ Aftercare Needs ☐ Other: ____________________

I certify that this authorization is made freely, voluntarily and without coercion. Provision of services is not contingent upon such consent and of the need for such releases. I understand the information to be released is protected under State and Federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by State and Federal law.

______________________________ ______________________________

Patient Signature *(required)* Date Legal Representative Signature Date

______________________________ Relationship to Patient: ☐ Parent ☐ DSS

Witness Signature Date ☐ Legal Custodian ______________

A clear and legible photocopy of a consent for release of information shall be considered to be as valid as the original.

Form #: M-025B (Rev. 05/14)