best day
PSYCHIATRY AND COUNSELING, PC

Consent to Request or Release Personal and Medical Information

I, _____hereby request and authorize:
Consumer Name/Date of Birth

a. **Best Day Psychiatry and Counseling, PC** to use or disclose my protected health information to _____
Address: _____ Telephone: _____ Fax: _____

b. _____ to provide or disclose my protected health information to Best Day Psychiatry and Counseling.
Address: 2587 Ravenhill Drive, Fayetteville NC 28303 Phone: 910-323-1543 Fax: _____

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.
Nature of records to be released: (*Please initial beside each applicable document*):___ Admission Assessments

_____Medications	_____ Treatment Plans	_____Treatment Recommendations
_____ Psychiatric Evaluations	_____ Psychological Evaluations	_____ Progress/Psychotherapy Notes
_____Discharge Summaries	_____Aftercare Plans/Orders	_____ Lab Results
_____Alcohol/Drug Treatment	_____AIDS/HIV	_____Other: _____

_____ *Please Release ALL my healthcare information* _____ *Specific Dates:* _____ *to* _____

I understand the purpose of the disclosure/re disclosure will be used for:_____

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit re disclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that re disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws. This consent will expire_____ (*specific date)* not more than 365 days from the date of signature.
When this authorization is requested from the consumer, a copy of this signed release form shall be provided to the consumer or legally responsible person. The consumer authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C-53(c).
I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, please notify Best Day Psychiatry and Counseling, PC in writing at 2587 Ravenhill Dr, Fayetteville, NC 28303.
I understand that I may refuse to sign this release of information form. I understand that Best Day Psychiatry and Counseling, PC may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form.

_____	_____	_____
Signature of consumer/legally responsible person	***Relationship***	***Date***