FAMILY PSYCHIATRY
PRACTICE & ASSOCIATES

ATTENTION: RELEASE OF MEDICAL INFORMATION AND CONFIDENTIALITY AUTHORIZATION FORM

Please check one:
I authorize FPPA to ☐ obtain/use ☐ disclose to ☐ to both obtain and disclose to

Please check if this applies:
I authorize FPPA to correspond via email* ☐ with me ☐ with person listed below

to disclose or obtain:

Name of Person or Facility:		
Address, City, State, Zip		
Phone:	Fax:	Email:

the protected health information of:

Patient Name:	Date of Birth	SS# (last 4)
Address	City, State, Zip	
Phone	Email:	

Put a CHECKMARK next to the purpose of the request:

☐ Attorney/Legal	☐ Continued Patient Care	☐ Educational / IEP & 504
☐ Diagnostic Clarification	☐ Transfer of Patient Care	☐ Insurance
☐ Social Services/Disability	☐ Other:	

Put a <u>CHECKMARK</u> next to how the above document(s)/information may be sent/obtained:

☐ Mail to Address Listed for Person or Facility	☐ FAX to # Listed Above (Urgent or Prioritizes)	☐ Pick Up at FPPA Office

Family Psychiatry Practice & Associates Information:

Phone
(919) 233-4131

Fax
(919) 233-4168

Email
frontdesk@fppa.com

Address
1400 Crescent Green Suite 120
Cary, North Carolina 27518

Please Complete and Sign The Back Page of this Authorization

I understand that:

- I may revoke this authorization at any time:
  - the revocation will not apply to information that has already been released in response to this authorization
  - I must revoke this authorization in writing. The procedure for revoking this authorization is to present my written revocation to the Family Psychiatry Practice & Association (FPPA), 1400 Crescent Green, Suite 120, Cary, NC 27518

- I may refuse to sign this authorization:
  - Family Psychiatry Practice & Association (FPPA) will not condition my treatment, any payment, or eligibility for benefits on receiving my signature on this authorization.

- A fee may be charged for copying of the protected health information

I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked according to the above directions, this authorization will expire on the following date, event, or condition: _____or upon the satisfaction of the need for disclosure: _____.

If I fail to specify an expiration date, event or condition, this authorization will not expire.

I have read and understand the information in this authorization form.

Signature of Individual: *if over 18 years of age*	
Printed Name:	Date:

-OR-

Signature of Authorized Representative:	
Printed Name:	Date:
Please Explain Representative's Relationship To The Individual:	

Please Submit Completed Form via Fax to 919-233-4168