REID WHITESIDE, Ph.D., P.C.
1616 Evans Road, Suite 202; Cary, North Carolina 27513
Phone (919) 677-8700 ■ Facsimile (919) 651-1007
DrWhiteside@ReidWhiteside.com
https://securecontact.me/drwhiteside@reidwhiteside.com

REQUEST and CONSENT FOR THE RELEASE and/or EXCHANGE of PROTECTED HEALTH INFORMATION

_____ _____
PATIENT'S NAME **Birthdate**

I authorize release of information FROM: **Reid Whiteside, Ph.D., P.C. TO:** [ ]

I authorize release of information **FROM**: [ ] **TO: Reid Whiteside, Ph.D.,P.C.**

_____ Exchange information via any confidential modality, OR _____ exchange information only via: _____.

☐ Check box to authorize the release/exchange of any and all information **necessary for the purpose**(s) specified below.

OR, if you did not check the above box for *"any and all necessary,"* then you must specify below what information to release:

_____ Administrative *(*Financial, billing, claims, attendance, and insurance)
_____ Medical/health history and substance use; medication treatments
_____ Referral information, chief complaint, problem list, diagnosis, risks
_____ Treatment plan/modality, progress, termination summary, prognosis
_____ Copies of all reports and summaries prepared or received
_____ Psychological testing reports and data
_____ Educational / academic &/or work information
_____ Legal, custody, & litigation-related information
_____ Correspondence with patient, family, & others
_____ Report prepared for specific purpose (specify):

I request that specified information be released or exchanged for the **purpose(s)** checked below (CHECK one or more):
_____ At my request
_____ Employment purposes
_____ Educational purposes, e.g., placement, IEP, etc.
_____ To facilitate assessment and treatment and/or collaboration
_____ Use by attorney, parent coordinator, court or government agency
_____ Other, specify:

I understand that my clinical (medical) records may include sensitive information, possibly including test results, substance abuse, diagnoses, marital relations, custody/co-parenting issues, etc., which is protected by federal and state law (however, this Request and Consent does not authorize release of *Psychotherapy Notes*). By signing below, I voluntarily waive or abridge my privacy rights by requesting and authorizing the actions specified above. I have the right to revoke this authorization at any time by notifying the parties above in writing, except that revocation will not be effective to the extent that action has already been taken on the authorization or if this authorization was provided as a condition of obtaining insurance coverage or reimbursement, or if ordered by a court or agency with jurisdiction. I understand that information disclosed pursuant to the authorization is beyond the control of the professionals specified, may be subjected to re-disclosure by the recipient, and may be no longer protected by HIPAA. I authorize use of copies/facsimiles, including an electronic version of this form and my signature, to authorize the disclosure. I release and discharge the parties specified above, their owners and staff, and business partners/associates from any and all liability, costs and claims arising from the release. I will pay any reasonable costs charged by the professionals made to fulfill this request including preparation of special reports. The parties are authorized to release information regarding substance use disorder and treatment compliance if pertinent. This authorization will expire 180 days after termination or last date of service unless another date is specified herein: _____.

Health care providers and other professionals may charge a reasonable fee to cover the costs incurred in searching, reviewing, copying, summarizing, and mailing medical records. These may include per page or flat rate copying fees. Additionally, fees may include fixed or hourly charges for the preparation of reports, calls and emails as necessary, and for time necessary to complete forms necessary to fulfill this request for exchange. I accept responsibility for payment of costs that may be incurred.

Signature: _____

Date signed: _____

Witness's signature: _____

Witness' printed name and phone: _____

_____ Check if signed by an adult patient
_____ Check if signed by the parent of patient who is a minor

(If by parent, print your name: _____)

_____
Signature of minor, other parent, spouse, etc. if indicated