AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ___________________________________ of ____
(Name) (Address)

____
(City, state) (Zip code)

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 until one year. I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, 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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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