CENTER FOR PEDIATRIC BEHAVIORAL HEALTH

## AUTHORIZATION TO EXCHANGE INFORMATION

LAST NAME: FIRST NAME: MIDDLE INITIAL:

ADDRESS:

PHONE: ( ) BIRTHDATE:

THIS DOCUMENT AUTHORIZES INFORMATION REGARDING THE ABOVE-NAMED PERSON BE EXCHANGED BETWEEN THE FOLLOWING ENTITIES:

CENTER FOR PEDIATRIC BEHAVIORAL HEALTH, PLLC
720 ST. JAMES DRIVE WILMINGTON, NC 28403

| Myself | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Primary Care Physician | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Psychiatrist | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Occupational Therapist | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Physical Therapist | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Speech-Language Pathologist | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Gastroenterologist | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Allergist | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| School | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Other: | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Other: | | |
|---|---|---|
| Name: | Practice/Agency: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

DISCLOSURE IS LIMITED TO:

1. ☐ Records regarding medical history, condition, diagnosis and treatment, and may include information regarding Mental Health, Alcohol and/or Drug Abuse or HIV/AIDs condition unless I indicate in the spaces below that I do not want such records released. Psychotherapy notes are not included, regardless.
2. ☐ I do not want to release records relating to Mental Health, Alcohol and/or Drug Abuse
3. ☐ I do not want to release records relating to HIV/AIDS condition

THIS AUTHORIZATION IS **VALID FOR 24 MONTHS AFTER SIGNATURE** UNLESS REVOKED.

I understand that I may revoke this authorization at any time by notifying the Center in writing. I understand that any such revocation will not apply to protected health information that has already been released prior to the revocation. I further understand that the information disclosed pursuant to this authorization may potentially be re-disclosed to persons who are not required to protect that information, but that information concerning mental health treatment by an area or state facility, information regarding AIDS status, and any information relating to alcohol or drug abuse treatment by a federally assisted program is subject to a prohibition on redisclosure, unless specific authorization is given. I understand that health care treatment for the client may not be conditioned on signing this authorization.

| | | |
|---|---|---|
| Legal Guardian's Printed Name | Legal Guardian's Signature | Date |