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CONSENT FOR THE RELEASE AND/OR EXCHANGE OF CONFIDENTIAL INFORMATION

Name of patient, student, or client: _____ DOB: _____

I authorize _____ to release _____ any and all information necessary to
(Dr. or agency that should send records) *Initial above*

Who should receive information? _____
(Dr. or agency that should receive records; specify address or fax number)

ADDITIONALLY, for the exchange of protected information:

I authorize _____ to release _____ any and all information necessary to
(FROM) *Initial above*

Entity to receive information: _____
(TO)

Via _____ Any appropriate modality, or only: ___ Phone / face-to-face, ___ facsimile, ___ mail, ___ E-mail

Information specified below if “any and all necessary” was **not** initialed above:

- | | |
|---|--|
| <input type="checkbox"/> Financial, billing, claims, attendance, and billing | <input type="checkbox"/> Medical and health issues |
| <input type="checkbox"/> Reports and data from psychological testing | <input type="checkbox"/> Educational / academic |
| <input type="checkbox"/> Summary report of diagnostic assessment, recommendations, and treatment progress | |
| <input type="checkbox"/> Other (specify): | |

I request that specified information be released or exchanged for the **purpose(s)** checked below:

- | | |
|--|---|
| <input type="checkbox"/> At my request | <input type="checkbox"/> To facilitate assessment and treatment |
| <input type="checkbox"/> To facilitate collaboration | <input type="checkbox"/> Other: |

By signing, I authorize and agree to the actions specified above. I understand that I have the right to revoke this authorization at any time by notifying the parties specified 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 and the insurer has a right to contest a claim, or if court-ordered. I understand that information used or disclosed pursuant to the authorization is beyond the control of the professionals specified, and consequently may be subjected to re-disclosure by the recipient and no longer protected by HIPAA. I authorize use of a copy, including an electronic copy of this form, to authorize the disclosure of the information requested. I release and discharge the parties specified above, their owners and staff, and business partners/associates from any and all liability, cost and claims arising from the release of this information. I will pay any reasonable administrative costs charged by the professional parties incurred in responding to this request. The parties are authorized to release information regarding substance use disorder if pertinent. This authorization will expire 45 days after services are officially terminated.

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

Date signed: _____ If signed by parent, print parent’s name: _____

Witness: _____
Adult witness’ printed name and phone number (if not signed in Dr. Whiteside’s office):

90-411 Record copy fee. A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying and mailing medical records. The maximum fee for each request shall be 75 cents per page for the first 25 pages, 50 cents per page for pages 26 through 100, and 25 cents for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of \$10.00, inclusive of copying costs. Fee may not exceed \$100.00.