Gregory Narron M.D.
AND ASSOCIATES

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# CONSENT FOR RELEASE OF CLIENT INFORMATION

Name _____ DOB _____

I hereby authorize Gregory Narron M.D. And Associates , PLLC to... ☐ RELEASE ☐ OBTAIN ☐ VERBALLY COMMUNICATE specified information in my medical/client/educational record for the purpose of continued mental health care.

_____
(Individual, Facility, or Organization)

_____
(Address)

_____ _____
(Phone Number) (Fax Number)

**This data shall include the available items checked below:**

☐ Communication Only
☐ Discharge Summary
☐ Admission Summary
☐ Laboratory Results
☐ Progress/Treatment Notes
☐ Psychological Testing
☐ Initial Evaluation
☐ Educational Testing
☐ Medication Log
☐ Other

Disclosure and/or exchange of the protected health and account information as authorized above may include communication by phone, fax or mail. This disclosure and/or exchange may include information regarding drug, alcohol or sexual abuse, psychological or psychiatric impairments, HIV and/or AIDS or other physical conditions. If the authorized individual or entity that receives or releases this information is not a health insurance plan or health care provider covered by federal privacy regulations (HIPAA), the released information may be re-disclosed at will by the recipient or sender without the consent of the patient or guarantor and may no longer be protected by federal or state law. If I refuse to sign this form, I understand that it will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or eligibility for health benefits. NOTE: This consent does not expire; however, it may be revoked at any time IN WRITING, except to the extent that any action has already been taken prior to revocation. I have read and understood the above statements and I consent to the release of the protected health and account information as indicated above. I also understand that there may be costs incurred with this request. Any such costs will be in compliance with State copying laws.

_____ _____
Patient (or Guardian's) Signature Witness

_____
Date