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CONSENT FOR RELEASE OF 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