GREW, MORTER & HARTYE, P.A.
3141 John Humphries Wynd, Suite 275
Raleigh, NC 27612

CONSENT FOR EXCHANGE OF PATIENT INFORMATION

This form when completed and signed by you, authorizes Grew, Morter & Hartye, P.A. to exchange protected information from your clinical record to the person you designate.

Patient Name _____ Birth Date _____

I authorize Grew, Morter & Hartye, P.A. to exchange

Information to be exchanged:
__ Psychological/Diagnostic Evaluation __Educational Assessment __ School Records
__ Progress Update __Medical History __ Developmental History

Other (specify):_____

This Information should only be exchanged with: Name/Agency_____
Address _____

Purpose of Release: I am requesting my psychologist to exchange this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

__ Continuity of Care __Educational __Other ____At the request of the individual

This authorization shall remain in effect until _____(fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).
_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____
If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.

_____ _____ _____
Signature of Parent/Guardian Date Relationship