1611-B OWEN DRIVE | FAYETTEVILLE, NC 28304
1140 KILDAIRE FARM RD., STE 308 | CARY, NC 27511
1451 S. ELM-EUGENE ST., STE 3215 | GREENSBORO, NC 27406
(O) 910.483.5884 | (F) 910.483.5864

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Client Name: ____

Date of Birth: ___________________________ Date(s) of Treatment ____

THRIVE INTERNAL INFORMATION RELEASE:

From: ____________________________________ (CLINICIAN NAME) **To**: ____________________________________ (CLINICIAN NAME)

RELEASE OF INFORMATION FROM THRIVE TO OTHER AGENCY:

From: Thrive Counseling & Consulting, 1611-B Owen Drive Fayetteville, NC 28304 **POC:** ______________________________

To: ____

(AGENCY) (ADDRESS) (PHONE/FAX)

POC: ____

RELEASE OF INFORMATION FROM OTHER AGENCY TO THRIVE:

From: ____

(AGENCY) (ADDRESS) (PHONE/FAX)

POC: ____

To: Thrive Counseling & Consulting, 1611-B Owen Drive Fayetteville, NC 28304 **POC:** ______________________________

Purpose for Release:

Coordination for Care Legal Representation Other ____

NOTE: Records from other agencies must only be released by that agency with permission of the client.

Information to be Released:

Dates of Treatment only	Educational Assessment	Appointment Schedule
Case Summary	Psychological Evaluation	Other ____________

If other, please specify: ____

Limitations (specify): ____

- I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent (unless provided for by state and federal laws).
- I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not revoked, this consent will expire on _____/_____/_____ or 12 months from date of signature.

____

PRINTED NAME/SIGNATURE OF PATIENT *DATE*

____

PRINTED NAME/SIGNATURE OF PARENT(S)/GUARDIAN(S)/REPRESENTATIVE(S) *DATE*

____

PRINTED NAME/SIGNATURE OF WITNESS, CLINICIAN, OR OFFICE ADMIN *DATE*

I, ____ (*CLINICIAN NAME*), have read this authorization for my client's request for release of information and understand what I am to provide as records for my client.

____

PRINTED NAME/SIGNATURE OF CLINICIAN *DATE*

Updated 5.30.19 I hereby revoke the above release of information effective (date)____________ (signature)____________________________