CARY COUNSELING CENTER

Suite 220 875 Walnut St. Cary, NC 27511 467-1180

Your Name: ______________________ Today's Date: ______________

IT IS THE POLICY OF CARY COUNSELING CENTER TO RECOMMEND THAT YOU ALOW US TO INFORM YOUR PERSONAL PHYSICIAN OF OUR SERVICES TO YOU. THIS POLICY IS TO HELP ENSURE OUR RESPONSIBILITY TO COORDINATE CARE AMONG PROVIDERS. PLEASE INDICATE BELOW IF YOU ARE WILLING TO GRANT SUCH PERMISSION.

(1) ____ I do not have a personal physician **OR** _____ (2) I do not want my personal physician notified **OR** (3) _____ Yes, I authorize my therapist and Cary Counseling Center to release the following information: **Diagnosis, psychological and emotional status and treatment plan.**

If you granted authorization to release the information, please complete the following:

This information should only be released to: (Physician name, address & telephone # to whom the information is to be released:

Physician's Name: ______________________________

Practice Address: ______________________________

Physician's Phone Number: ____________________ Physician's Fax #: ______________

I am requesting that this information be released at my request for the following reasons: **coordination of care.**
This authorization shall remain in effect until **180 days following my last service appointment at Cary Counseling Center.**

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

I understand that my therapist and Cary Counseling Center generally may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information for a third party. I understand that information use for disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPPA Privacy Rule.

______________________________ ______________

Signature of Patient Date

______________________________ ______________

Signature of Legal Guardian & Relationship to Patient Date

(THIS SECTION FOR OFFICE USE ONLY)

TH: ____________________ DX: ____________________

PL: ______________________________

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