Fortis Behavioral Health
220 Wintergreen Dr., Suite B
Lumberton, NC 28358
910-536-1719
910-668-8048

Name:

Date of Birth:

I hereby authorize Fortis Behavioral Health to:

☐ Obtain ☐ Release ☐ Verbally Communicate

Specified information in my medical/client/educational records for the purpose of continued mental health care.

Name of doctor/clinic/or other entity:

Address, phone number, and fax number:

This data shall include the available items selected below:

☐ Communication only
☐ Treatment notes
☐ Educational testing
☐ Medication log
☐ Laboratory results
☐ Initial evaluation
☐ Admission summary
☐ Full patient file
☐ Progress notes
☐ Discharge summary
☐ Psychological testing

Other specific information to be released:

Purpose for which the disclosure is being made:

☐ Medical treatment ☐ Attorney ☐ Insurance ☐ School

*Disclosure and /or exchange of the protected health and account information as authorized above may include communication by phone, fax, or email. This disclosure and/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 or healthcare provider covered by federal privacy regulations (HIPPA), the released information may be re-disclosed at will by the recipient or sender without the consent of patient or guarantor and may no longer be protected the 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 Signature:

Date:

Name of SIGNER (and relationship to patient if not signed by the patient):