FORTIS
BEHAVIORAL HEALTH

Fortis Behavioral Health
220 Wintergreen Drive, Suite C
Lumberton, North Carolina, US - 28358-7502

Consent Form- ROI DDS

Consent Form - Records Release

Name: *

Date of Birth: *

I hereby authorize Fortis Behavioral Health to: *
☐ obtain ☐ Release

Specified information in my medical/client/educational records for the purpose of disability determination services.

Release to: Disability Determination Services
SSA-36 NC DDS Raleigh
P.O. Box 8700
London, KY 40742-9805

Fax Number:866-885-3235

This Data Shall Include The Available Items Checked Below: *

☐ Communication Only ☐ Laboratory Results ☐ Progress Notes
☐ Initial Evaluation ☐ Discharge Summary
☐ Treatment Notes ☐ Educational Testing ☐ Admission Summary
☐ Psychological Testing ☐ Medication Log

Other specific information to be released:

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 psychiatricimpairments, 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.

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PATIENT OR PARENT/GAURDIAN SIGNATURE: *

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

Relationship to patient: *

Date: *