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

Consent Form- ROI FMLA

Consent Form - Records Release

Name: *

Date of Birth: *

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

specified information in my medical/client records for the purpose of the completion of FMLA paperwork

Please provide the name of company the information is being released to and Point of Contact:

Please provide the address, phone number, and fax number of the place of Company:

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:

Purpose for which disclosure is being made: * ☐ Attorney ☐ Insurance ☐ Work

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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.

PATIENT SIGNATURE: *

Name of SIGNER:

Date: *