

## RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

*This form, when completed and signed by you, authorizes the release of protected information from your clinical record to Serenity Mental and Medical Care, PLLC or from another provider to Serenity Mental and Medical Care, PLLC.*

I authorize the exchange of information between the following:

**Information to be released from/to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Information to be released to/from:**

Serenity Mental and Medical Care, PLLC  
430 Magnolia Square Court  
Aberdeen, NC 28374  
910-637-0052  
**910-637-0210 (Fax)**

Purpose of Release of Information:

\_\_\_ Continuity of Care

\_\_\_ Legal Representation

\_\_\_ Insurance

\_\_\_ Request of the Individual

\_\_\_ Other (Please specify): \_\_\_\_\_

This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with these individuals or companies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information. I understand that information may be shared in writing, via email, in electronic form and/or in meetings or by telephone. This release will automatically expire 12 months from the date of signature.

I understand that I can withdraw this consent at any time by submitting a written revocation to Serenity Mental and Medical Care, PLLC. The revocation will not apply to information that has already been released.

I understand that information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may then no longer be protected under the HIPAA Privacy Rule.

\_\_\_\_\_  
Patient signature

Date

\_\_\_\_\_

\_\_\_\_\_  
Patient Parent/Guardian signature Relationship to patient

\_\_\_\_\_ Date

Witness \_\_\_\_\_

**Rescind Consent:** I hereby rescind the prior consent granted to Serenity Mental and Medical Care, PLLC, to release and/or discuss any information with the individuals(s)/agencies listed above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_