Asheville Integrated Behavioral Health, PC
30 Clayton Street, Asheville, NC 28801
Ph: 828-423-0537; Fax: 828-333-4362
whamiltonphd@behealthavl.com

Authorization to Release Protected Information

(APA HIPAA Compliant: 4/03)

I, ____ hereby authorize:

Name and contact details for people (such as healthcare provider, family member, etc):

____
____
____

To **exchange** (two-way share)
Or (circle): release to Dr. Hamilton or receive from Dr. Hamilton

My confidential medical records and protected health information involving assessment or treatment with:

Asheville Integrated Behavioral Health, PC
William Hamilton, PhD
30 Clayton Street
Asheville, NC 28801
FAX (828) 333-4362 [secure FAX]

Without Exclusions
Or limited to or specifically excluding: ____

For the purpose of: to help with diagnosis and treatment planning
Or specify other purpose: ____

I have the right to revoke this authorization, in writing, at any time by sending such written notification to William Hamilton's office address. Any such revocation will not be effective to the extent that the releasing parties have taken action in reliance on the authorization, and that this authorization was obtained as a condition for obtaining insurance coverage, and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of this information, and may no longer be protected by the HIPAA Privacy Rule.

Today's date: _____/______/______

This authorization shall remain in effect until one year from today's date, or ending ____/____/____ per my specification. I also acknowledge that I have the right NOT to authorize this release of my health information, and I do so freely of my own accord.

____________________________________ ____________________________________
Signature **Printed Name**

Date of Birth:______/______/_______

_______________________________________ (Witness/Guardian Signature and Printed Name)