ALLEN MELVIN, MD, PA
3315 Springbank Lane Suite 302
Charlotte NC 28226
Phone: 704.644.7885 Fax: 704.353.7275

CONSENT TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

I, _____ Date of Birth _____

authorize Allen Melvin, MD, PA at the above address to:

☒ Release and/or receive my clinical information from the following health care provider(s):

(name, address, phone) _____

(name, address, phone) _____

☒ Release and/or receive my clinical information from the following therapist:

(name, address, phone) _____

☒ Exchange clinical information with the following nonhealth care provider, e.g. family member, friend, etc:

(name, address, phone) _____

This information is for the following purposes and any other use is prohibited:

_____

This authorization is valid for one year OR until _____ (up to one year).

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I also understand that I may revoke this authorization at any time and that I will be asked to sign a Revocation, a separate form that will be provided. I further understand that any action taken on the authorization prior to the rescinded date is legal and binding. I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that I may request a copy of this signed authorization.

_____ _____ _____

Signature of Individual/Guardian/Personal Representative Date Signed Print Name

_____ _____ _____

Signature of Witness Date Signed Print Name

FOR OFFICE USE ONLY
Person Releasing Information _____
Date Information Released_____