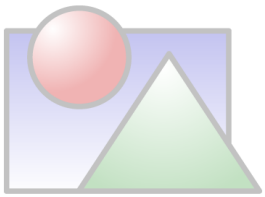
Release and Consents

Confidential

Please print and submit to therapist as original signatures must be filed



Release Of Information:

Carl Potter, LCSW
5003 Southpark Dr. Suite 100
Durham, NC

27713
Phone: 919-619-1498
Fax:
www.cp3psych.com

I, Name _____ authorize Carl Potter, LCSW to release medical record information to, or receive it from, the following parties:

Name of Parties: _____

This release is regarding:

It will contain the following information:

Responsible Party's Signature: _____

Date: _____

This release will be valid for the duration of 12 months and then will be renewed if necessary.

Consent To Use And Disclose Your Health Information:

This form is an agreement between you, Name _____, and I, Carl Potter, LCSW, and includes any dependents, relatives, or other person included below.

When I treat, refer, test, or diagnose you, I will be collecting what the law calls *protected healthcare information (PHI)*. I will use that information for treatment formulation and treatment planning. I may also share this information with others who provide treatment for you or those persons who are involved with insurance reimbursement, business, and government functions. By signing this form, you are agreeing to let me use your PHI for the above mentioned purposes. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read it before you sign this form.

IF YOU DO NOT SIGN THIS CONSENT FORM AGREEING TO WHAT IS IN MY NOTICE OF PRIVACY PRACTICES I CANNOT TREAT YOU.

In the future, I may change how I use and share your information. Which would mean a change in the NPP. If I do change it, you can get the new version from my website: cp3psych.com. If you are concerned about some of your PHI, you have the right to refuse disclosure for treatment, payment, or administrative purposes. You must present this request in writing. As explained in the NPP, I am not required to agree to these limitations but I will do my best to comply with your privacy wishes. At any time, after you have signed this consent, you may revoke your consent for disclosure. This must also be submitted in writing.

Signature of client or personal representative: _____

Printed name: _____

Assignment And Release:

I, the undersigned certify that I (or my dependent) has insurance coverage stated in the insurance portion of the registration forms and assign payment directly to entity named in the registration documents all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor/therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance. I am entitled to a copy of this agreement by requesting same.

Responsible Party Signature: _____

Relationship: _____ Date: _____

For Office Use Only: DX_____ Date of First Visit:_____Therapist/DR_____