Mosaic
Psychological Center

Authorization for Release of Information

Client Name_____ **Date**_____

Date of Birth_____

I, _____, hereby authorize Mosaic Psychological Center, PLLC to exchange my medical records including any psychiatric, alcohol, or drug abuse information contained with _____. Such release is limited to the following:

_____Intake Information _____Progress Notes

_____Billing Information _____Psychological Testing

_____Treatment Plan & Goals _____Verbal Summary of Our Work Together

_____Discharge _____Other: _____

This information is needed for _____.

This authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon. I understand there are laws and regulations governing the confidentiality of my medical records and data concerning my treatment; specifically, N.C. General Statute 122 and, if drug and alcohol related, federal regulations (42 CFR Part 2). I further understand the data cannot be disclosed without my written consent unless provided for in the Notice of Privacy Practices. The information disclosed may not be further disclosed or used for any purpose other than as stated in this authorization.

This authorization is valid until _____.

Client Signature_____Date_____

Parent/Guardian Signature_____Date_____

5970 Fairview Road, Suite 414 | Charlotte, North Carolina 28210 | Tel: 704-774-0459 | Fax: 980-498-7881
mosaicpsychcenter.com