Matt Riley Psychotherapy
(828) 536-0799
matt@mattrileypsychotherapy.com
PO Box 8212
Asheville, NC 28814

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

Patient Name: _____
Date of Birth: _____
Phone Number: _____
Dates of Treatment: _____

I authorize Matt Riley, MSW, LCSWA of Matt Riley Psychotherapy to receive and disclose Protected Health Information from my medical record. The purpose of this release and exchange is to clarify diagnosis, formulate a treatment plan, and coordinate care.

The information released may include treatment summary, pertinent psychiatric and treatment history, mental health diagnosis and evaluation, and any information necessary to coordinate care between Matt Riley Psychotherapy and the physician or office listed below.

I authorize a two-way release of this information between Matt Riley Psychotherapy and the physician or office listed below. This two-way release may include Protected Health Information from treatment dates associated with any and all of my treatment provided by Matt Riley Psychotherapy and the physician or office listed below.

Provider Name: _____
Provider Office: _____
Office Phone: _____
Office Address: _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Date