# Authorization To Release Information To CEH

**135 Mocksville Avenue**
**Salisbury, NC 28144**
**P: (704) 237-4240**
**F: (704) 547-3150**
**Email: medicalrecords@cehcharlotte.com**

**Patient Information:**

First Name: _____ Last Name: _____

DOB: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

**Releasing Provider / Organization:**

Name of Provider / Organization: _____

Phone Number: _____ Fax Number: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

**Information To Be Released (check all that apply):**

- ☐ All patient records
- ☐ Treatment Notes / Progress Notes
- ☐ Medication List
- ☐ Lab Results
- ☐ Other (please specify): _____

**Purpose of Disclosure:**

- ☐ Continuity of Care
- ☐ Insurance/Billing
- ☐ Legal Purpose
- ☐ Other: _____

By signing this form, I authorize the release of my protected health information **to Center For Emotional Health** as described above.

X_____ X_____

Signature of Patient Date