

AUTHORIZATION TO RELEASE INFORMATION

Client Name (Last, First, Middle or Maiden Name)		Social Security No.	Date of Birth
Name/Address of Agency, Organization or Individual which Possesses Information to be Released Cherry Hospital Caller Box 8000 Goldsboro, NC 27533 ATTENTION: Medical Records/Correspondence		Name/Address of Agency, Organization or Individual To Whom Information is to be Released Beaufort County Sheriff's Office 210 North Market Street Washington, NC 27889	
Information Requested (Specify the nature and extent of information to be released) Information Specific to Mental Health Services		Purpose(s) or Need for which the Information is to be Used Concealed Weapon Permit Application	

I hereby request and authorized the above-named agency, organization or Individual which possesses information relative to the client named above to release information, as specified, to the agency, organization or individual named on this request. I understand that the information to be released may include information regarding drug abuse, alcohol abuse, sickle cell anemia, psychological or psychiatric impairments and AIDS or HIV test results if applicable.

I certify that this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under state and federal laws and cannot be redisclosed without my further written consent unless otherwise provided for by state or federal law. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

A photocopy of this authorization may be considered as valid as the original.

_____	_____
Signature of Client	Signature of Legally Responsible Person (when required)
_____	_____
Signature of Witness	Date

_____ A search of our medical records revealed that the above-named individual does not have a medical record associated with Cherry Hospital, Goldsboro, N. C.

_____ A search of our medical records revealed that the above-named individual does have a medical record associated with Cherry Hospital, Goldsboro, N. C.

Information Check by: _____
Signature/Title Date