AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED INFORMATION

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This authorization form implements the requirements for Patient authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164; the federal drug and alcohol confidentiality law, 42 C.F.R. part 2; and state confidentiality law governing mental health, developmental disabilities, and substance abuse services, G.S. 122C. This form will also be used as a two-way release form.

Client Name:	DOB:
Address:	

I, _____, hereby authorize
(Client and/or Legally Responsible Person)

_____
(Name of general designation of program or person making disclosure)
to release the following specified information in my record **to/from:**

_____
(Name of person or organization to which disclosure is to be made. Include address/phone if known.)

_____

Purpose of the disclosure authorized:

☐ Service Delivery ☐ Continuity of Care ☐ Referral ☐ Service Authorizations and Reimbursement for Services ☐ Clinical Supervision ☐ Update Records ☐ Other: _____

Data may be released in written, verbal, or electronic form, and may include copies of the following information:
(Please check all applicable information, enter N/A if not requested)

____	Comprehensive Clinical Assess.	____	Psychological/Educational Testing Results
____	Psychiatric History and Evaluation	____	Urine Drug Screen(s)/Breathalyzer(s) Results
____	(HIV/AIDS) History and Treatment	____	Alcohol or Substance Use History and Treatment
____	General Progress in Treatment	____	Service/Progress Notes
____	Treatment Plan	____	Medication History/Physician Orders
____	Discharge Summary	____	Special Tests as Indicated _____
____	Videotape __ Audiotape __	____	Reciprocal Exchange
____	Appointment Compliance	____	Program Compliance
____	Diagnosis(es)	____	Other

The data marked above may include all dates, unless otherwise specified: _____

Notice of Voluntariness

The doctrine of authorization has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this authorization is truly voluntary and is valid until such request is fulfilled, but not to exceed one year. I further acknowledge that I may revoke this authorization in writing, at any time. I may revoke the authorization except to the extent that action based on this authorization has already been taken. In any event, if not revoked earlier, this authorization expires automatically after 365 days or event related to the client or the purpose of the authorization (whichever is earlier).

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Redisclosure:

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other law,s, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2) we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two law. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these law.

Signatures

_____	_____	_____
Client's Printed Name	Signature of Client	Date
_____	_____	_____
Legally Responsible Person or Personal Representative's Printed Name	Signature of Legally Responsible Person	Date

Please explain Representative's authority to act on behalf of Client: _____

_____	_____	_____
Witness' Printed Name	Signature of Witness	Date

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. HIPAA and Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. With regard to alcohol and drug abuse patients, 42 CFR Part 2 restricts any use of the information to criminally investigate or prosecute.

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Revocation and Expiration

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy).

Entity for which release is being revoked: _____

To revoke this authorization please complete the following information:

I, _____ withdraw the right to have this information released.

_____	_____	_____
Client's Printed Name	Signature of Client	Date
_____	_____	_____
Legally Responsible Person or Personal Representative's Printed Name	Signature of Legally Responsible Person	Date

Please explain Representative's authority to act on behalf of Client: _____

_____	_____	_____
Witness' Printed Name	Signature of Witness	Date