

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

45 C.F.R. Parts 160 and 164; 42 C.F.R. Part 2; G.S. 122C

This authorization form implements the requirements for client 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 the state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122 C).

CLIENT'S NAME: _____ RECORD NUMBER: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

I, _____, authorize **PEACE OF MIND, INC**
Name of client or client's legally responsible person Agency or person authorized to use and disclose the information

to use or disclose to/with _____
Name of agency or person to whom the requested use or disclosure will be made (include address, if applicable)

THIS DATA SHALL INCLUDE *(Initial beside data to be used or disclosed)*

- | | | |
|--|--|---|
| <input type="checkbox"/> Assessments | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Substance Abuse/Treatment |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Service Plans/Goals | <input type="checkbox"/> HIV/AIDS Information |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Social, Developmental, Medical History |
| <input type="checkbox"/> Diagnoses | <input type="checkbox"/> Financial/Reimbursement | |
| <input type="checkbox"/> Other: _____ | | |

PURPOSE OF USE OR DISCLOSURE *(Initial beside reason for disclosure)*

- | | | |
|---|--|---|
| <input type="checkbox"/> At the request of the individual | <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Coordination of Care |
| <input type="checkbox"/> Court Proceedings | <input type="checkbox"/> Determination of Benefits | <input type="checkbox"/> Other _____ |

Information requested should be mailed to this address: _____

REDISCLASURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, 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 disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCAION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the agency's Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

Date of expiration, if less than one year Event, if less than one year

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that _____ will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

Signature of legally responsible person, if required Date

Please explain LRP authority to act on behalf of the client:
 Power of Attorney Guardian _____
 Other: _____ Staff Signature