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 _____
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)***

____Assessments ____Progress Notes ____Substance Abuse/Treatment
____Psychiatric Evaluations ____Service Plans/Goals ____HIV/AIDS Information
____Psychological Evaluations ____Discharge Summary ____Social, Developmental, Medical History
____Diagnoses ____Financial/Reimbursement
____Other: _____

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

____ At the request of the individual ____Assessment/Evaluation ____Coordination of Care
____ Court Proceedings ____Determination of Benefits
____ Other _____

Information requested should be mailed to this address: _____

REDISCLOSURE

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.

REVOCATION 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, and enrollment in a health plan or eligibility for benefits if I refuse to sign.

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

_____ _____
Signature of legally responsible person, if required Date Signed

Please explain LRP authority to act on behalf of the client:
☐Power of Attorney ☐ Guardian

_____
Witness Signature

_____
Date Signed

☐Other: _____