

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)*

- 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: _____

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 _____