New Hope Psychiatric Services of the Carolinas, PLLC

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client: _____

DOB: _____

Insurance ID # _____

- Use this form to obtain client or legally responsible person/personal representative authorization for the release of information
- Form must indicate whether this is to release information, obtain information, or both.
- Form must be completely filled out before client or legally responsible person/persons representative signs
- File original form in client record. MUST GIVE COPY TO CLIENT

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 45 C.F.R. Parts of 160; 42 C.F.R., Part 2; G.S. 122C

This 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 state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I, _____, **authorize** New Hope Psychiatric Services of the Carolinas, PLLC
(Client or client's legally responsible person or personal representative) (Agency or person authorized use or disclose the information)

☐ to obtain from: ☐ to release/disclose to: _____

_____

_____

(Agency or person to whom the requested use or disclosure will be made)

The following protected information: labs, visit notes, ongoing communication, etc

_____

_____

(Ex. Psychiatric Assessment; Psychological Assessments; Progress Notes; Treatment Plan; Medication Records; Screening)

The Purpose of the disclosure is: To provide continual care

_____

_____

_____

(Describe each purpose of the requested use or disclosure)

REDISCLOSURE

Once information is disclosed pursuant to this authorization, I understand that the federal health 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 laws, however, may prohibit re-disclosure. When this agency discloses 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 laws. Our Privacy Notice describes the circumstances where disclosure is permitted or required by these laws. I understand that the information to be released may include information regarding drug abuse Alcohol abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke are explained in New Hope Psychiatric Services of the Carolinas, PLLC Privacy Notice, a copy of which has been provided to me.

If not revoked earlier, this authorization expires automatically upon: _____
(Date or event that relates to the client or the purpose of the use or disclosure)

NOTICE OF VOLUNTARINESS

I certify that this authorization is made freely, voluntarily and without coercion. I understand that New Hope Psychiatric Services of the Carolinas, PLLC cannot deny or refuse to provide treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign this authorization, except in limited circumstances, i.e. Research related treatment, services provided solely for reason of creating PHI for disclosure to 3rd party.

Signature: _____ **Date:** _____

Please explain authority of person signing above to act on behalf of client: _____

Signature: _____ **Date:** _____
(Minors Signature-only required if minor has a substance abuse diagnosis)