

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Client's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Medical Record # \_\_\_\_\_

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION – 45 CFR Parts 160 and 164; CFR, Part 2; G.S. 122C** This form implements the requirements for client authorizations to use and disclose health information protected by the federal health privacy law (45 CFR parts 160, 164), the federal drug and alcohol confidentiality law (42 CFR part 2 and state confidentiality law governing mental health, developmental disabilities and substance abuse services (G.S.122 C).

I, \_\_\_\_\_ authorize Carolina Dunes Behavioral Health  
*(Client's name or client's legally responsible person or personal representative)* *(Agency or person authorized to use or disclose the information)*

to disclose to \_\_\_\_\_  
*(Agency or person to whom the requested use or disclosure will be made)*

\_\_\_\_\_  
*(Address of Agency or person to whom the requested use or disclosure will be made)*

**TYPE OF INFORMATION TO BE DISCLOSED**

**This data shall include: (Client / Guardian Initials by EACH appropriate block)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dates of Treatment                    | <input type="checkbox"/> Diagnosis                                 | <input type="checkbox"/> Financial Information |
| <input type="checkbox"/> Admission Assessment                  | <input type="checkbox"/> Case Management Assessment / Notes        | <input type="checkbox"/> Insurance Information |
| <input type="checkbox"/> Psychological Evaluation              | <input type="checkbox"/> Psychiatric Evaluation                    | <input type="checkbox"/> IPRS                  |
| <input type="checkbox"/> Person-centered Plans / Plans of Care | <input type="checkbox"/> Psychiatrists Progress Notes              | <input type="checkbox"/> NC TOPP               |
| <input type="checkbox"/> Discharge Summary                     | <input type="checkbox"/> Medication History / Physician's Orders   |  |
| <input type="checkbox"/> Lab results: Specify type: _____      | <input type="checkbox"/> Verbal communication related to treatment |  |
| <input type="checkbox"/> Other: (Specify) _____                |  |  |

**I understand this information will be used for: (Client / Guardian Initials by EACH appropriate block)**

- Insurance / Medicaid / IPRS determinations of benefits and billing purposes
- To assist in the development of individual service / goals plans
- To assist in securing benefits from entitlement programs
- Provide data to assist with evaluation / assessment / prescriptive services
- Coordination of services between agencies
- Other: (Specify) \_\_\_\_\_

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 45 CFR Parts of 160 and 164: 42 CFR, Part 2: G.8. 122C I understand that the information to be released may include information regarding drug abuse, alcohol abuse, sexually transmitted diseases, HIV Infection, AIDS or AIDS related conditions, psychiatric information or physical impairments.**

**REVOCAION 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 CAROLINA DUNES BEHAVIORAL HEALTH'S Privacy Notice, a copy of which has been provided to me.**

If not revoked earlier, this authorization expires automatically upon: \_\_\_\_\_ or one year from the date it is signed, whichever is earlier

**NOTICE OF VOLUNTARINESS**

**I certify that this authorization is made freely, voluntarily and without coercion. I understand that CAROLINA DUNES BEHAVIORAL HEALTH 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 a third (3<sup>rd</sup>) party.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please explain authority of person signing above to act on behalf of client:** \_\_\_\_\_

Signature of MINOR: \_\_\_\_\_ Date: \_\_\_\_\_

**(MINORS SIGNATURE ONLY REQUIRED IF MINOR HAS A SUBSTANCE ABUSE DIAGNOSIS)**