

*DRG Counseling, Inc.*

**Client Name: Date of Birth:**

**Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby authorize:**

Name of Organization/person who is to disclose the information: **DRG Counseling, Inc.**

Relationship to Client: \_\_\_Treatment Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_5720 Creedmoor Rd., Suite 201/203, Raleigh, NC 27612\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/Fax: \_919.977.6018 / Fax: 919.300.7471\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

**To disclose/release my identified information (written and/or verbally) to the following organization/person:**

Name of Organization/person who is to receive the information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following information may be disclosed/released from my record:**

***Please have the client put their initials next to each item that is to be released:***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Assessment Information |  | Medical Diagnosis |  | Educational Records |
|  | Financial Information |  | Mental Health Diagnosis |  | Progress Notes/TX Planning |
|  | Benefits/ServicesNeeded |  | Physical Health Records |  | Criminal Justice Records |
|  | Housing Information |  | Psychological Records |  | Employment/Voc. Records |
|  | Medication Information |  | Laboratory Records |  | Hospital Discharge Planning |
|  |  |  |  |  |  |

**The purpose of the release authorized:**

|  |  |  |
| --- | --- | --- |
| **Continuum of Care:**  Medical Provider or Hospital  Psychiatric Provider  Therapy  Counseling  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Benefit Information:**  Financial  Insurance  Housing  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Referral for Services |
| Persons Involved in Treatment  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Emergency Contact |
| Other Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**The following information will NOT be released unless you specifically authorize it by putting your initials in the relevant spaces below:**

\_\_\_\_\_\_ I specifically authorize the release of information pertaining to any drug and alcohol abuse, diagnosis

or treatment.

\_\_\_\_\_\_ I specifically authorize the release of information pertaining to any HIV/AIDS testing and results.

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individuals/organizations identified above from making any further disclosure of this information unless further disclosure is expressly permitted by me or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that my records are protected by the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I understand that my records are also protected under the Federal privacy regulations within the Health Insurance Portability & Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information that is specified above will be disclosed pursuant to this authorization and that it may no longer be protected by the HIPAA privacy law.

The Federal regulations governing Confidentiality of Alcohol & Drug Abuse Patient Records, 42 C.F.R., Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug abuse program from re-disclosure.

I further understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.

This authorization is valid from the date in which I sign this authorization and will remain in effect until whichever following event occurs the earliest: 1) The date I revoke this authorization, 2) the date I am discharged from Dynamic Resources & Guidance, Inc. / DRG Counseling, Inc. or 3) one year from the date in which I sign this authorization.

Signature of Client/Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date: \_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_

Signature & Title of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\* Disclaimer \*\*\*\*\***

Please Note: During COVID-19, DRG Counseling, Inc. will Accept Forms filled out in Word / PDF and will Accept Full Client Name Written, in lieu of their signatures. This is a temporary situation, since we understand that many individuals might not have access to Printer and/or Scanner while working remotely. We are making this exception as a Good Faith Effort to accommodate Client needs during this time.