PO Box 2469 – 306 North Queen Street
Kinston, NC 28502
Tel. (252) 208-0027 Fax (252) 208-0029

AUTHORIZATION TO RELEASE HEALTH INFORMATION

To Permit Use and Disclosure of Health Information
This authorization form implements the requirements for consumer authorization to use and disclose Health Information protected by the Federal Health Privacy Law, 45 C.F.R., parts 160 and 164. The federal Confidentiality law, 42 C.F.R., part 2, and State Confidentiality Law governing Mental Health Developmental Disabilities and Substance Abuse Services NC §122C.

I, ____
(Client Name)

request and authorize ____ to use or disclose health
(Name of person/agency/facility authorized to make disclosure)

information to ____ the protected health
(Person/agent/facility, and address, to which the requested use or disclosure will be made)

information (including HIV related information, if applicable) indicated below:

Client/Guardian must initial each category to be disclosed. Enter "N/A" beside items not requested.

_________Admissions/Screening/Assessment/Client Profile
_________Service Notes/Progress
_________Treatment Plan
_________Medication Hx/Physician's Orders
_________Psychological Evaluation
_________Lab/Medical Information
_________HIV Related Information
_________Substance Abuse Information
_________Psychiatric Evaluation
_________Attendance/Appointments
_________Legal Involvement/Legal History
_________Verbal Case Discussion
_________Other ____

Purpose of Disclosure:

_____Continuity of Care _____Referral _____Legal _____Service Delivery _____Other_______________________

I understand that the information to be released may include information regarding HIV and/or AIDS status, drug abuse, alcohol abuse, or psychological or psychiatric impairments.

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Parts 160 and 164 and HIPPA) protecting health information may not apply to the recipient of the information and therefore may not prohibit the recipient from disclosing it. Other laws, however, may prohibit redisclosure. When this agency disclosed mental health and developmental disabilities information protected by state law (NC § 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.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing by giving the written notice of revocation to ENC Psychological Services, PLLC by delivering the written notice to the office manager at 304 North Queen Street, Kinston, NC 28502. I understand that any action taken on this authorization prior to the rescinded date is legal and binding and will not effect any actions taken by ENC Psychological Services, PLLC before receiving this notice of revocation. If not revoked earlier, this authorization expires 6 months (for minors) or one year (for adults) from the date it is signed.

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that ENC Psychological Services, PLLC cannot deny or refuse to provide treatment, payment, and enrollment in a health plan, or eligibility for benefits on my refusal to sign. I further understand that I may request a copy of this signed authorization.

Client (or parent/guardian if a minor) ____

Or Legally Appointed Representative ____

Witness ____

Date Signed ________________________ Valid from ________________________ to ________________________

Client Name: ____________________________________ DOB/Chart #: ____________________________________

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REVOCATION SECTION

I do hereby request that this authorization to disclose the health information of ______________________________
(Name of Client)

signed by ______________________________ on ______________________________
(Name of person who signed authorization) (Enter date of signature)

be rescinded, effective ______________________________. I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

______________________________ ______________________________
Signature of client, parent or guardian) (Date)

______________________________ ______________________________
(Signature of legal representative) (Date)

____
(Relationship of legal representative

______________________________ ______________________________
(Signature of Witness) (Date)

Client Name:______________________________ DOB/Chart #:______________________________