Carolina Psychiatry

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 from implements the requirements for client authorization and 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. 122C)

CLIENTS' NAME:_____ **PATIENT NUMBER**: _____

DATE OF BIRTH:_____ **SSN**:_____

I, _____, do hereby authorize Carolina Psychiatry, P.C. 548 Sandhurst Drive Fayetteville, NC 28304 to use, exchange or disclose to/with (Please list name of agency or person to whom the requested use or disclosure will be made. Include name and address if applicable below)

_____

Fax:_____ **Phone**: _____

THIS DATA SHALL INCLUDE (Client is encouraged to initial beside data to be used or disclosed)

___Assessments
___Psychiatric Evaluations
___Psychological Evaluations
___Diagnoses
___Service Notes
___Service Plan/ Goals
___Other:_____

___Discharge Summary
___Financial/Reimbursement
___Substance Abuse/Treatment
___HIV/ AIDS Information
___Social, Developmental, Medical History

Information requested should be mailed to this address:

Carolina Psychiatry P.C. 548 Sandhurst Drive Fayetteville NC, 28304 or Faxed to 910-484-3404.

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 and 164) protecting health information may not apply to the recipient of the information protected by state law (G.S. 122C) or substance abuse treatment information protected health information protected by federal law (42 C.F.R. Part), we must inform the recipient of the information that disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, and 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:_____ Event, if less than one year:_____

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that Carolina Psychiatry, P.C. will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____	_____	_____
Client (Print)	Client (Signature)	Date
_____	_____	_____
Parent/ Legally Responsible Person (Print)	Parent/ Legally Responsible Person (Signature)	Date
_____	_____	_____
Witness (Print)	Witness (Signature)	Date