**CLIENT:**
**RECORD#:** **SH #:**
**DOB:**
**Medicaid/NCHC #:**

# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize **HARNETT COUNSELING SERVICES, P.C.** to
*Name of consumer/legally responsible person*

☐ **RELEASE PROTECTED HEALTH INFORMATION TO:** ☐ **OBTAIN PROTECTED HEALTH INFORMATION FROM:**

Agency/Person: _____
Address (if applicable): _____

**THIS DATA SHALL INCLUDE:**

| | | |
|---|---|---|
| ____Assessments | ____Psychotherapy Notes | ____Substance Abuse/Treatment |
| ____Psychiatric Evaluations | ____Service Plans/Goals | ____HIV/AIDS Information |
| ____Psychological Evaluations | ____Discharge Summary | ____Social, Developmental, Medical History |
| ____Diagnoses | ____Financial/Reimbursement | ____Other:_____ |

____Verbal &/or written exchange of all information regarding mental health treatment for coordination of care
____ Verbal &/or written exchange of all information regarding academic, behavioral and social functioning for coordination of care

**PURPOSE OF USE OR DISCLOSURE***:*

| | | |
|---|---|---|
| ____At the request of the individual | ____Assessment/Evaluation | ____ Coordination of Care/Continuity of Treatment |
| ____Court Proceedings | ____Determination of Benefits | ____ Other_____ |

**My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. Additionally, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.**
**If not revoked earlier, this consent shall be valid for 365 days from the date signed unless otherwise indicated below:**

_____ _____
***Date of expiration, if less than one year*** ***Event/Condition if less than one year***

**When this authorization is requested from the consumer, a copy of this signed release form shall be provided to the consumer or legally responsible person. The consumer authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C-53(c).**

**I understand that I have the right to revoke this authorization at any time. I understand that any action taken on this authorization prior to the rescinded date is legal and binding. To revoke this authorization, send a written statement to Lisa McGee, Harnett Counseling Services, PO Box 1921, Lillington, NC 27546 and state that you are revoking this authorization**

**I understand that I may refuse to sign this authorization form. I understand that Harnett Counseling Services, P.C. may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign this form.**

**I understand that Harnett Counseling Services, P.C. may charge a reasonable fee for copies of my medical records.**

_____ _____ _____
**Signature of Consumer/Legally Responsible Person** **Relationship** **Date**

_____ _____
**Minor Signature (required for SA)** **Date**

_____ _____
**Witness (required if mark used by consumer/legally responsible person)** **Date**

Post Office Box 1921, Lillington, NC 27546
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infoharnettcounseling@yahoo.com