Consumer Authorization for Use and Disclosure of Protected Health Information

Client: **Date of Birth:**

☐ 315 E. Washington St. Greensboro, NC 27401 ☐ 407 E. Washington St. Greensboro, NC 27401 ☐ 1401 Long St. High Point, NC 27262 ☐ 902 Bonner Dr. Jamestown, NC 27282 ☐ 308 Boulevard St. High Point, NC 27262

By signing this form, I authorize FAMILY SERVICE OF THE PIEDMONT, INC. to: ☑ Use or disclose information to: ☑ Obtain information from:

Name:

Agency: Sandhills Center

Address: 1120 Seven Lakes Dr.,

West End, NC

Phone: 8002562452 Fax:

The following protected health information is authorized to be released or obtained:

☑ Identifying Information (Name, SSN, DOB, Race / Ethnicity, Address, Phone No.

☑ Drug / Alcohol Diagnoses / Treatment

☑ Comprehensive Clinical Assessment / Diagnoses

☑ Treatment Recommendations

☑ Service Plan (including adherence)

☐ Psychotherapy Notes

Other:

☑ Drug Screen Results

☑ Aftercare Plan

☑ Appointment Date / Time / Attendance

☑ Financial / Billing Information

☑ Medical Consultation

☑ Medical / Lab Reports

Purpose of use / disclosure:

☑ Continuity of Care

☐ Ongoing Communication

☑ Request of Client / Representative

☑ Compliance with Treatment Needs

☑ Verification of Services

☑ Reimbursement Purposes

This information may be shared:

☑ Written ☑ Verbally ☑ Electronically ☑ Faxed

☐ I understand that the health information used and disclosed may include information such as HIV infection, AIDS-related conditions, alcohol use, drug use, psychological or psychiatric conditions.

RE-DISCLOSURE

☐ Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and therefore may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or information collected for North Carolina Treatment Outcomes and Program Performance (NC-TOPPS), we must inform the recipient of the information that re-disclosure is prohibited except as permitted by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

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NOTICE OF VOLUNTARINESS

☐ I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Family Service of the Piedmont cannot deny or refuse to provide treatment on my refusal to sign, but I will be responsible for all fees that may be denied as a result of my refusal to sign.

EXPIRATION

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

☐ I wish to review information before it is released.

I have read and understand the information in this authorization form and have been offered a copy, which:

☐ I accept ☐ I decline ***A photocopy of this authorization is as valid as the original***

☐ I am the client ☐ I am a responsible party Name: