Fresh Start Counseling Center/ Holly Johnson, LPC, NCC

Authorization for Use & Disclosure of Protected Information

Client Name: Insurance: Medicaid Number:	Record Number: LME Number:

Client Date of Birth: _____ Social Security Number: _____

This form implements the requirements for client authorization 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 state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I hereby authorize: _____

Total number of individuals or agencies listed above:_____ Total number of individuals or agencies listed below: _____

To ☐ Disclose and/or ☐ Share Protected Health Information via: ☐fax ☐mail ☐phone ☐in person ☐email (HIPPA compliant)

with:_____

_____

The protected information to be used/disclosed includes: (Check all that apply)

☐Admission Assessment(s) ☐Risk Assessment
☐Evaluation(s) ☐Substance Abuse Information
☐Plans of Care I Service Plan ☐HIV Information
☐Progress Notes (list dates)
☐Other: _____

_____

I understand the purpose of the disclosure is for: _____

REDISCLOSURE

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 redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 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 laws.

REVOCATION AND EXPIRATION

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). The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Fresh Start Notice of Privacy Practices, a copy of which has been offered/provided to me.

If not revoked earlier, this authorization expires automatically upon: _____ (Date or event that related to the client or the purpose of the use or disclosure) when treatment episode ends or one year from the date it is signed, whichever is earlier.

NOTICE OF VOLUNTARIES

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Fresh Start Counseling Center cannot deny or refuse to provide treatment, payment, enrollment in the health plan, or eligibility for benefits on my refusal to sign.

SIGNATURES:_____/_____ Date:_____

Signature of Client Printed Name of Client

Additional Signature of Parent/Guardian if needed_____Date:_____

Specify Relationship to Client and Print Name in Full: _____

This authorization was explained and a copy was offered/provided to the client:

Witness: _____Date:_____