Fortitude Counseling Services

Helping you find the strength to persevere through life's challenges!

Authorization for use and disclosure of Protected Health Information

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Phone: 336-609-3737 Fax: 336-232

Client: _____

DOB: _____

- Use this form to obtain client or legally responsible person/personal representative authorization for the release of information
- Form must indicate whether this is to release information, obtain information or both
- Form must be completely filled out before client or legally responsible person or persons representative sign
- File original in client record and give a copy to the client

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 45 C.F.R. PARTS OF 160; 42 C.F.R., PART 2; G.S. 122C

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45C.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, _____, authorize Fortitude Counseling Services to

___obtain from and _____release/disclose to: _____

_____

The following protected information psychiatric assessments, evaluations, medication records, screenings, treatment plans and progress notes_____

The purpose of this disclosure is: Continuity of Care_____

Re-disclosure

Once information is disclosed pursuant to this 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 may prohibit re-disclosure. 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 re-disclosure is permitted or required by these laws. I understand that the information to be released may include information regarding drug abuse, alcohol abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric or physical impairments.

Revocation and Expiration

I understand that with certain exceptions, I have the right to revoke this authorization at anytime, except to the extent that action has been taken in reliance on it. The procedure for how I may revoke this authorization, as well as exceptions to my right to revoke have been explained to me by Fortitude Counseling and will be provided in writing should I request it.

If not revoked earlier, this authorization expires automatically upon: _____

Notice of Voluntariness

I certify that this authorization is made freely, voluntarily and without coercion. I understand that Fortitude Counseling Services cannot deny or refuse to provide treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign this authorization, except in limited circumstances.

Signature: _____ Date: _____

Please explain authority of person signing above to act on behalf of client: _____

Signature: _____ Date: _____