STRATEGIC BEHAVIORAL CENTER 3200 Waterfield Dr. Garner, NC 27529 ~Phone: 919-800-4400 ~ Fax: 919-573-4163

AUTHORIZATION TO RELEASE AND OBTAIN CONFIDENTIAL INFORMATION

Client's Full Name: _____ Date of Birth: _____/_____/_____

Medical Record # _____ Social Security Number # _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFOMRATION – 45 CFR Parts 160 and 164; CFR, Part 2; G.S. 122C This form implements the requirements for client authorizations to use and disclose health information protected by the federal health privacy law (45 CFR parts 160, 164), the federal drug and alcohol confidentiality law (42 CFR part 2 and state confidentiality law governing mental health, developmental disabilities and substance abuse services (G.S.122 C).

I, _____ authorize Strategic Behavioral Center

(Client's name or client's legally responsible person or personal representative) *(Agency or person authorized to use or disclose the information)*

to obtain or disclose to _____ _____

(Agency or person to whom the requested use or disclosure will be made)

_____

(Address of Agency or person to whom the requested use or disclosure will be made)

TYPE OF INFORMATION TO BE OBTAINED OR DISCLOSED

This data shall include: (Client / Guardian Initials by <u>EACH</u> appropriate block)

_____ Dates of Treatment
_____ Admission Assessment
_____ Alcohol / Drug History
_____ Legal History
_____ Person-centered Plans / Plans of Care
_____ Discharge Summary
_____ Lab results: Specify type: _____
_____ School (attendance, grades, IEP, education)
_____ Other: (Specify) _____

_____ Diagnosis
_____ Case Management Assessment / Notes
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Psychiatrists Progress Notes
_____ Medication History / Physician's Orders
_____ Verbal communication related to treatment

_____ Financial Information
_____ Insurance Information
_____ IPRS
_____ NC SNAP
_____ NC TOPPS

I understand this information will be used for: (Client / Guardian Initials by <u>EACH</u> appropriate block)

_____ Insurance / Medicaid / Medicare / IPRS determinations of benefits and billing purposes
_____ To assist in the development of individual service / goals plans
_____ To assist in securing benefits from entitlement programs
_____ Provide data to assist with evaluation / assessment / prescriptive services
_____ Coordination of services between agencies
_____ Other: (Specify) _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 45 CFR Parts of 160 and 164: 42 CFR, Part 2: G.8. 122C I understand that the information to be released may include information regarding drug abuse, alcohol abuse, sexually transmitted diseases, HIV Infection, AIDS or AIDS related conditions, psychiatric information or physical impairments.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time, 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 the exceptions to my right to revoke, are explained in STRATEGIC BEHAVIORAL CENTERS Privacy Notice, a copy of which has been provided to me.

If not revoked earlier, this authorization expires automatically upon: _____ or <u>one year</u> from the date it is signed, whichever is earlier

NOTICE OF VOLUNTARINESS

I certify that this authorization is made freely, voluntarily and without coercion. I understand that STRATEGIC BEHAVIORAL CENTER 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, i.e. research related treatment, services provided solely for reason of creating PHI for disclosure to a third (3rd) party.

Signature: _____ Date: _____

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

Signature of MINOR: _____ Date: _____

(MINORS SIGNATURE ONLY REQUIRED IF MINOR HAS A SUBSTANCE ABUSE DIAGNOSIS)