

HEALTHPLUS THERAPEUTIC SERVICES

NORTH CAROLINA DIVISION OF MH/DD/SAS
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION
(45 C.F.R. Parts 160 and 164; 42 C.F.R. Part 2; G.S. 122C)

This authorization form implements the requirements for consumer authorization to use and disclose health information protected by the federal privacy law, 45 C.F.R. parts 160 and 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.

Consumer Name: _____ Date of Birth: _____
Social Security or Other Consumer ID: _____ Record Number: _____

I, _____, request and authorize
Name of consumer or consumer's legally responsible person/personal representative

_____ to release/receive specified information
Name of agency/person/facility authorized to use or disclose the information

concerning me for use and/or disclose to/from _____
Name of agency/person/facility to whom the requested use or disclosure will be made

The data to be released/received may include the following protected information:
(Each box checked must be initialed by the person authorizing the use/disclosure)

- Checkboxes for: Treatment/Habilitation Plan, Current Medicines, Diagnosis, Psychological Testing, Progress Notes/Reports, Fact of Admission, Psychiatric Evaluation, Substance Abuse Information, HIV/AIDS Information, Intake/Screening Assessment, Other - Specify

Specific Purpose: [] Continuity of Care [] Service Delivery [] At the Request of the Individual
[] Other: _____

I understand that I may revoke this authorization at any time except that action has been taken in reliance on it (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy). In any event, if not revoked earlier, this authorization expires automatically:

[] upon satisfaction of the need for disclosure; [] within (1) year from the date signed; [] under the following conditions:

Consumer Signature: _____ Date: _____

Please print name: _____

Legally Responsible Person/Personal Representative Signature: _____

Date: _____ Please print name: _____

Please explain representative's authority to act on behalf of consumer: _____

PLEASE SEE BACK OF FORM FOR ADDITIONAL INFORMATION

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REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal 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. Upon disclosure of 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), this organization informs the recipient of the information 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. I understand I have the right to review the Notice at anytime. Copies of the notice are available at anytime upon request by calling 252-321-0400.

REVOCAION AND EXPIRATION

If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer.

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that Healthplus Therapeutic Services will not condition the consumer's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization.

OFFICE INFORMATION