

CenterPoint Human Services
4045 University Parkway
Winston Salem NC 27106
(336) 714-9100

CONSUMER AUTHORIZATION

To Permit Use and Disclosure of Health Information

This authorization form implements the requirements for consumer authorization to use and disclose Health Information protected by the Federal Privacy Law, (HIPAA) 45 C.F.R. parts 160- 164; the Federal Confidentiality Law, 42 C.F.R. part 2, and State Confidentiality Law governing Mental Health, Developmental Disabilities, and Substance Abuse Services G.S. 122C.

Client Name _____ Record Number _____

DOB _____ SSN _____

Requests and authorizes _____ to use or disclose
(Name of agency/person/facility/or program authorized to make disclosure)

the Protected Health Information indicated below **(including HIV & Substance Abuse related information if applicable)**

to _____
(Agency/person/facility or program to whom the requested use or disclosure will be made)

***Please indicate information to be disclosed.**

_____ Admission/Screening Assessment	_____ Service Plan	_____ Service Notes
_____ Medication Hx/Physicians Orders	_____ Psychological testing	_____ HIV Related Info.*
_____ Discharge Information	_____ Substance Abuse Information	_____ Psychiatric Evaluation
_____ 3rd Party Information *	_____ Accounting of Disclosure	_____ 508 DWI Form

Purpose of disclosure: Continuity of Care Referral Legal Service Delivery Other

Other information (if not listed): _____

***(HIV or other communicable disease related information may be a part of multiple documents in the record)**

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will not be protected by state and federal privacy and confidentiality laws and that it could be redisclosed by the person or agency that receives it.

* I understand that by indicating I authorize 3rd Party Information to be disclosed, any Protected Health Information (PHI) from other treatment facilities contained in this medical record will be shared pursuant to this authorization; including substance abuse information.

I understand that with certain exceptions, I have the right to revoke this authorization at any time **(orally or by submission of written notification)**. The procedure for revoking authorizations as well as the exceptions to my right to revoke is explained in CenterPoint Humans Services **Notice of Privacy Practices**. If you do not have the **Notice of Privacy Practices** you may request one from the receptionist.

The meaning of this authorization form has been explained to me. I understand that I may refuse to sign this authorization form. I understand that CenterPoint Human Services will not condition treatment on receiving my signature on this authorization. I understand this authorization is made freely, voluntarily and without coercion. I understand the health information indicated will be disclosed per my instructions.

This authorization is effective only for the following period of time (not to exceed 12 months):

From: _____ To: _____

My authorization is withdrawn if any of the following occur:

Event: _____

Condition: _____

Consumer or Legal Guardian/Parent of Minor: _____ **Date:** _____
(if 18+ years of age, proof of Legal Court Appointed Guardianship documents must be presented to sign as guardian)

Witness: _____ **Date:** _____

(Rev.3/2009) dm

Original

Authorization for Use and Disclosure