north carolina solutions

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

1. Client Name: _____ Last 4 #s of SSN: _____
Date of Birth: _____ Phone Number: _____

2. INFORMATION TO BE RELEASED FROM:

_____
_____
_____
_____

INFORMATION TO BE RELEASED TO:

Name: _____
Address: _____
_____
Phone: _____

3. INFORMATION AUTHORIZED FOR RELEASE *(CHECK ALL THAT APPLY)*:

☐ Psychiatric Evaluation ☐ Medications ☐ Medical/Physical history
☐ Discharge Summary ☐ Labs ☐ History/Psychosocial
☐ Psychiatrist Notes ☐ Nursing Notes ☐ Therapy Notes
☐ Other: _____

4. RELEASE OF SPECIAL RECORDS

YOU MUST ☒ CHECK A RESPONSE TO EACH of the following statements in the event your record may contain such information:

a. ☐ **I DO** ☐ **I DO NOT** authorize disclosure of records of alcohol or drug abuse treatment.

b. ☐ **I DO** ☐ **I DO NOT** authorize disclosure of records of diagnosis of HIV or AIDS (including test results).

Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164. These rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

5. PURPOSE FOR USE OR DISCLOSURE: ☐ Personal Use ☐ Treatment ☐ Legal ☐ Other _____

6. EXPIRATION: Unless another date, event or condition is listed below, this authorization will expire one (1) year from the date it is signed. Other date, event, or condition:

_____

7. *I understand RiverValley may not condition treatment or eligibility for care on my providing this authorization except if such care is (1) research related, or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. If Client refuses to provide authorization under the aforementioned circumstances, RiverValley may refuse to provide care or treatment for these purposes.*

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164) and the Privacy Act of 1974 (5 USC 552a) and the Client has the right to revoke this authorization at any time in writing and upon delivery to RiverValley, except to the extend that action has been taken in reliance of this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

_____ _____
Client Signature **Date**

_____ _____
Date

Signature of: ☐ Parent ☐ Guardian ☐ If other, specify relationship: _____

_____ _____
Witness Signature *(required for release of hospital records)* **Date**