Sandhills Best Care || Release of Information

Office Use Only
Client Name: _____ DOB: _____ Record #: _____

Staff Witness Signature: _____ Date: _____

_____ _____ _____
If from School System, School Counselors Printed Name | Phone Number | Email Address

Authorization for Use and Disclosure of Protected Health Information

This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 CFR 160, 164), the federal drug and alcohol confidentiality law (42 CFR 2), and the disabilities and substance abuse services (GS 122C).

Name: _____ Insurance #: _____

DOB: _____ SS#: _____ - _____ - _____

I, _____ (full name), authorize Sandhills Behavioral Care to use or disclose to/with

_____.
(Name of Agency or Person to whom the requested use or disclosure will be made)

This disclosure shall include (initial or check)	**Purpose of use or Disclosure (initial or check)**
____Assessments ____Psychiatric Evaluation ____Psychological Evaluation ____Diagnosis ____Service Notes/Progress Notes ____Service Plan/Goals/Treatment Plan ____Discharge Summary ____Financial Reimbursement ____Substance Abuse Treatment ____HIV/AIDS Info ____Social, Dev, Medical ____Other: _____	____ At the request of the individual ____ Coordination of Services ____ Determination of Benefits ____ Assessment/Evaluation ____ Court Proceedings ____ Other: _____ **Sandhills Best Care** Dr. Tammie Gainey (p) 910-562-9882 (f) 910-562-9955 (e) office@sandhillscares.com

Redisclosure

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 CFR 160, 164) protecting health information may not apply to the recipient of the information and therefore may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. When we disclose mental health and developmental disabilities information protected by state law (GS 122) or substance abuse treatment information protected by federal law (42 DFR 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or requested by these two laws.

Revocation and Expiration

I understand that with certain exceptions, I have the right to revoke this authorization at any time. The procedure of how I may revoke this authorization, as well as the exceptions to my right to revoke, have been explained to me. If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

_____ _____
Date of expiration, if less than one year | Event, if less than one year for revocation.

Notice of Voluntariness

I understand that I may refuse to sign this authorization form.

_____ _____
Signature of Patient/Student/Client | Date

_____ _____
Signature of Legally Responsible Person, if required | Date