AUTHORIZATION TO DISCLOSE MEDICAL RECORDS/INFORMATION

I authorize Verna Dority, MSW, CCSW, Inc and/or independent licensed therapists who contract with Verna Dority, MSW, CCSW, Inc to disclose the specific health and medical information identified below for:

Patient Name: ____ Date of Birth: ___________________

***TO*:**
Recipient Name: ____ Phone: _________________

Recipient Address: ____

for the following purposes: (describe each purpose of disclosure):

☐ **Coordination of Care** and/or ☐ **Coordination of Care/Service Order** and/or

☐ Other: ____

I understand that all alcohol and/or drug treatment records and all HIV diagnosis related information are protected under the Federal Regulations governing Confidentiality of Alcohol, Drug Abuse and HIV related patient records, 42 CFR Part 2 and G.S. 130A-143 and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.

I understand that the information to be disclosed may include information regarding drug abuse, alcohol abuse, HIV infection, AIDS, AIDs related conditions, psychological, psychiatric or physical impairments.

By **initialing** the spaces below, I specifically authorize the use, disclosure or release of the following health information and/or medical records, if such information and/or records exist:

_____ All Clinical records
_____Discharge Summary
_____Medication List
_____Appointment Dates
_____Alcohol and/or drug abuse information
_____Diagnosis (diagnoses)
_____Billing statements
_____Initial Diagnostic Evaluation & Mental Status Exam
_____Emergency and urgent care records
_____Progress Notes
_____Consultation
_____HIV related information
_____Specific Dates of Service: ____________________
_____Other ____________________________________

I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent (unless provided for by state and federal laws).

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be (re) disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this consent. Unless revoked earlier, this authorization will expire twelve (12) months from the date of signing or until (**applicable date or event)**: ____.

____
Printed Client Name or Legally Responsible Person

____ ________________________________
Signature of Client or Legally Responsible Person Date