FREEDOM HOUSE RECOVERY CENTER

CONSENT TO RELEASE/EXCHANGE INFORMATION

NORTH CAROLINA DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, SUBSTANCE ABUSE SERVICES

Client Name _____ MR # _____ Medicaid #__ _____ DOB _____

I hereby authorize the release/exchange of information to / from the following persons/agencies:

AGENCY
Freedom House Recovery Center

ADMINISTRATIVE OFFICE ADDRESS
104 New Stateside Drive, Chapel Hill NC 27516
Phone: 919-942-2803 x 2330Fax: 919-336-4656

To/from the following persons/agencies for the purpose of: ***(Please check all that apply)***

☐Assessment ☐Treatment planning ☐Referral ☐Coordination of services ☐Payment

☐Utilization management ☐Other_____

AGENCY (Write name of one agency or person per form) **ADDRESS/PHONE NUMBER/FAX**

Information may be released in written, verbal, or electronic form and may include copies of the following data to be released. Check applicable records/information to be exchanged:

☐ Psychological evaluations	☐ Academic/behavioral records	☐ Substance abuse information
☐ Assessments	☐Record of appointments	☐ Treatment Plans
☐ Physical /health records	☐ HEP/U-SP/T	☐ Service notes
☐ Progress Reports	☐ HIV/AIDS information	☐ Medication history
☐ Psychiatric Evaluations	☐ Vision/hearing evaluations	☐ Transition/discharge information
☐ Discharge Summary	☐ Diagnosis	
☐ Information related to benefits/needs, diagnosis, treatment intervention		☐ Other (specify):

I understand what information will be released/exchanged, the purpose for the release of the information, and that there are statutes and regulations protecting the confidentiality of the information. I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and therefore may not prohibit the recipient from re-disclosing it. I also understand that other laws may prohibit re-disclosure without consent of the consumer, parent(s), or legal guardian. I understand that consumers served shall receive appropriate treatment and continuity of care. In order to accomplish this, information may be shared in written and verbal forms between other agencies as deemed necessary. I understand the terms of this release and voluntarily give my consent. I understand that Freedom House Recovery Center will not condition my treatment, or any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this authorization. My consent shall be valid for a period of one year. I may revoke my consent by giving verbal or written notice, at any time. Such revocation does not affect the validity of my consent for information disclosed/released prior to the revocation. I further understand that I may refuse to sign this authorization form. I understand that I may request a copy of this signed consent.

Signed:_____ Date:_____

(Specify if signature is that of consumer ____, parent(s) ____, or legal guardian ___)

Witness: (required only if signature is an "X" mark or symbol) _____ Date:_____

This authorization is hereby revoked upon the signed and dated request of the consumer as noted below:

Consumer Signature: _____ Date:_____

The consumer has notified me verbally that he/she wishes to revoke this authorization with an effective date of:

Date:_____ Staff signature: _____ Date signed:_____

THE INFORMATION OF RELEASE IS CONFIDENTIAL AND REDISCLOSURE IS PROHIBITED EXCEPT AS AUTHORIZED BY G.S.122C-53 THROUGH G.S. 122C-56.

Important Disclosure Information for SA Consumers: : Substance Abuse Regulations (42 CFR 2.32) require that each disclosure made with the patient's written consent must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). State law (FS130A-143) further protects the confidentiality of information when a person has an AIDS/HIV virus infection. The Federal rules prohibit you from making any further disclosure unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.