Consumer Name: _____ Date of Birth: _____

Insurance Number:_____ Medical Record #: _____

21st Century Counseling, PLLC
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 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), the HIV/AIDS information law (N.C.G.S. 130A-143) and the state confidentiality law governing mental health, developmental disabilities and substance abuse services (G.S. 122 C).

Client Name: _____ Record#: _____

Date of Birth: _____ Insurance #: _____

I, _____, authorize 21st Century Counseling, PLLC clinician to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Patient or legally responsible person should initial each item to be disclosed)

_____ Assessment

_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. Coordination of care activities.

If the purpose is other than care coordination or filing insurance claims, please specify:
_____
_____

Expiration

Unless sooner revoked, this authorization expires will be valid for 1 year or as otherwise indicated:_____

Consumer Name: _____	Date of Birth: _____
Insurance Number: _____	Medical Record #: _____

Conditions

I further understand that 21st Century Counseling, PLLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: The clinician will be unable to coordinate care for the client. This action may have a negative impact on the well-being of the client.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 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 NCGS § 122C-53(c) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Legally Responsible Person, if Required Date