

A New Tomorrow Behavioral Health Services

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RELEASE OF INFORMATION & CONSENT FORM

Client's Name: _____ Date of Birth: _____

Parent/Guardian: _____

REQUESTING RECORDS

RELEASING RECORDS

I hereby authorize *A New Tomorrow* to release and/or exchange protected health information for the above stated client to:

Name of Applicable Professional & Organization: _____

Street Address: _____

City, State, & Zip Code: _____

Phone: _____ Fax: _____

The protected information to be released and/or exchanged includes:

Assessment

Diagnosis

Psychosocial Evaluation

Psychological Evaluation

Psychiatric Evaluation

Treatment Plan or Summary

Current Treatment Update

Progress in Treatment/Notes

Presence/Participation in Treatment

Nursing/Medical Information

Toxicological Reports/Drug Screen

Educational Information

Discharge/Transfer Summary

Continuing Care Plan

Medication Management Information

Demographic Information

Other _____

Other _____

Purpose of Contract: This form implements the requirements for client authorization/consent 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), and the state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

Redisclosure: Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. part 164) protecting health information may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

Revocation and Expiration: I understand that, with certain exceptions, I have the right to revoke this authorization at any time. (If I want to revoke this authorization, I must do so in writing). If not revoked, this authorization will expire automatically when treatment ends.

Notice of Voluntariness: I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that *A New Tomorrow* will not deny or refuse treatment because of my refusal to sign.

Signature of Client or Legal Guardian

Date

Relationship to Client