PCFT
Pamlico Child & Family Therapy

Permission to Obtain or Release Information

Client Name: _____ Client DOB: _____

Client Record #: _____ Insurance ID: _____

This authorization form implements the requirements of client authorization to use and disclose health information protected by the federal health privacy law, 45CFR Parts 160, 164; the federal drug and alcohol confidentiality law, 42 CFR, Part 2; and state confidentiality law governing mental health, developmental disabilities, and substance abuse services, GS 122C.

I, _____, hereby request and authorize the following to release/obtain information to help myself or my child get appropriate counseling services and interventions for the use and/or disclosure:

TO: Name: _____
Address: _____
Phone number: _____

FROM: Pamlico Child and Family Therapy
13814 NC Hwy 55 Bayboro, NC 28515
PO Box 408 Grantsboro, NC 28529
252-745-7401/Fax: 252-745-7400

This data shall include the following information *(mark all that apply):*

_____ Assessment(s)
_____ Diagnoses
_____ Service Plan/Treatment Plan
_____ Participation and Progress in Treatment
_____ Substance Abuse Treatment
_____ Psychotherapy Notes
_____ Other: _____

_____ Medical Information
_____ Educational Information
_____ Discharge/ Transfer Summary
_____ Demographic Information
_____ Psychological/Psycho-Ed Testing
_____ Group Therapy Notes

Time Period of Requested Information: _____

PURPOSE OF USE & DISCLOSURE

The purpose of this disclosure is for coordination of care.

This consent includes information to be exchanged in verbal, written, or electronic format.

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal 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. I understand that the information released may include drug and/or alcohol use and/or HIV/AIDS diagnosis ONLY with my specified consent. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2, G.S. 130A-143), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOKE AND EXPIRATION

I further understand that this consent is valid for one year or until permission is withdrawn. I understand that I may withdraw this permission at any time by providing a written request to the extent that action based on this consent has been taken, and that revocation will not condition my treatment. This consent is valid until _____ (365 days from providing consent).

_____

Name **Relationship to Client**

_____

Signature **Date**

_____

Witness **Date**