

LUTHERAN FAMILY SERVICES IN THE CAROLINAS

CLIENT NAME:

RECORD NUMBER:

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) and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122 C).

I, _____ authorize Lutheran Family Services
Name of client or client's legally responsible person Person and agency authorized to use and disclose the information

to use or disclose to/with _____
Name of person and agency to whom the requested use or disclosure will be made (include address, if applicable)

THIS DATA SHALL INCLUDE (client must initial beside data to be used or disclosed)

- | | | |
|--|--|---|
| <input type="checkbox"/> Assessments | <input type="checkbox"/> Service Notes | <input type="checkbox"/> Substance Abuse/Treatment |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Service Plans/Goals | <input type="checkbox"/> HIV/AIDS Information |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Social, Developmental, Medical History |
| <input type="checkbox"/> Diagnoses | <input type="checkbox"/> Financial/Reimbursement | |
| <input type="checkbox"/> Other: | | |

PURPOSE OF USE OR DISCLOSURE (client must initial beside data to be used or disclosed)

- | | | |
|---|--|--|
| <input type="checkbox"/> At the request of the individual | <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Coordination of Service |
| <input type="checkbox"/> Court Proceedings | <input type="checkbox"/> Determination of Benefits | <input type="checkbox"/> Other |

Information requested should be mailed to this address: 5712 Shattalon Drive #47
Winston Salem NC 27105

REDISCLASURE

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 redisclosing it. Other laws, however, may prohibit redisclosure. 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), we must inform the recipient of the information that disclosure 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.

REVOCAATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. Upon request, the procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke will be provided to me upon request. These procedures are explained in Lutheran Family Services' Notice of Privacy Practices, a copy of which will be given to me upon request. If not revoked earlier, this consent shall be valid for 90 days for one time releases or one year when the release is required for ongoing service provision, from the date signed unless otherwise indicated below:

Date of expiration (90 days/one year) _____
 Event, if less than 90 days/one year _____

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that Lutheran Family Services will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Signature of client _____ Date _____ Witness (required if symbol or mark is used by client or LRP) _____

Signature of legally responsible person, if required _____ Date _____

Please explain LRP authority to act on behalf of the client: _____
 Power of Attorney Guardian Other _____ Staff Signature _____

A copy of this consent was given to the client (client initials verifying receipt): _____

FILE IN RECORD WITH OTHER CONSENTS/ COPY TO CLIENT