AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

This authorization form implements the requirements for patient 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. 122C.

Patient Name: ____ Date of Birth: ______________________

I request and authorize PORT Health Services to communicate with and disclose to:
Name of Individual and Entity: ____
Address (street, city, state, zip code): ____
Phone Number: ______________________________ Fax Number: ______________________________

Information to be disclosed (Check all applicable boxes):

☐ Assessments ☐ Treatment Plan ☐ Laboratory Reports
☐ Medications ☐ Discharge Summary ☐ Treatment Summary
☐TB ☐ Progress Notes (excluding psychotherapy)
☐ Other (specify): ____

Information to be released for these dates of treatment: From ________________ To ________________

I understand that this consent for release of records <u>includes information related to</u> the treatment of Substance Use Disorders, psychological or psychiatric conditions, Human Immunodeficiency Virus (HIV) infection, AIDS or AIDS related conditions (NCGS 130A-143), sexually transmitted diseases, and gene-related impairments (including genetic test results).

Purpose of Use & Disclosure:

☐ Coordination of Care ☐ Legal Proceedings/Matters ☐ Billing & Reimbursement
☐ Seeking Financial Benefits ☐ Other (specify): ____

Redisclosure: I understand that the information may be redisclosed by the recipient and it may no longer be protected under the HIPAA Privacy Rule. However, other laws may prohibit redisclosure, and we are required to inform the recipient.

Voluntariness: This authorization is voluntary. Treatment and payment will not be affected if I refuse to sign this authorization, except as provided by law. A copy of this authorization is as effective as the original.

Revocation and Expiration: I may revoke this authorization in writing at any time by requesting a *Revocation Form* from the clinic's front desk, except to the extent that an action has been taken in accordance with this authorization. If not revoked earlier, this authorization will expire automatically one year from the date of signature or upon a certain event relevant to the purpose of this authorization (specify event): ______________________________

____ ______________________
Patient's Signature Date

____ ______________________
Legally Responsible Person's Signature (if required) Date

____ ______________________
Printed Legally Responsible Person's Name Relationship to Patient

Note: If the patient is unable to sign, a Legally Responsible Person may sign this form for the patient. Written evidence will be requested. For minor patients with substance use diagnosis, both patient and legally responsible person must sign.