AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED INFORMATION

45 C.F.R. Parts 160 and 164; 42 C.F.R. Part 2; G.S. 122C

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 substance use disorder confidentiality law, 42 C.F.R. part 2; and state confidentiality law governing mental health, developmental disabilities, and substance use services, G.S. 122C. **This is a two-way release of protected information.**

Patient Name: ____ DOB: _________________

I, ____, (Name of Patient or Patient's Legally Responsible Person) request and authorize

PORT Health Services to communicate and exchange with ____ (Name and/or Entity)

___________________ (Phone #) ____________________ (Fax #) the following protected information:

(Patient or Legally Responsible Person should **initial** each category that applies.)~~N/A with a line through~~ information you do not want to be disclosed.

_____	Substance Use Disorder Treatment	_____	Discharge Date and Plan	_____	Progress Notes (excluding psychotherapy notes)	_____	Progress and Compliance
_____	Assessments	_____	Laboratory Test Results	_____	Treatment Plan	_____	Tuberculosis
_____	Attendance	_____	Diagnosis	_____	Medications & Dosages		

_____ Other (Specify):____

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

☐ Payment ☐ Treatment ☐ Coordination of Care ☐ Emergency Contact ☐ Investigation/Legal Proceedings

☐ Other (specify): ____

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient form redisclosing it. Other laws, however, may prohibit redisclosure and we'll inform the recipient according to the state law (G.S. 122C) and federal law (42 CFR part 2). Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by laws.

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form and PORT Health Services will not condition my treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

REVOCATION AND EXPIRATION

I understand that I may revoke this authorization in writing at any time by requesting a Revocation Form from the front desk except to the extent that action has been taken in reliance on the authorization (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy). In any event, if not revoked earlier, this authorization expires automatically after 365 days from the date it is signed or event related to the patient or the purpose of the authorization (whichever is earlier).

______________________	______________________	____________
Patient's Printed Name	Signature of Patient	Date
______________________	______________________	____________
Legally Responsible Person's Printed Name (if required)	Signature of Legally Responsible Person	Date

Please explain Legally Responsible Person's authority to act on behalf of Patient: _________________________________

______________________	______________________	____________
Staff Witness' Printed Name	Staff Witness' Signature	Date