Family Service
OF THE PIEDMONT

Consumer Name	_____
Case Number	_____

CONSUMER AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date of Birth:		**Medicaid Number:**	

☐ 315 E. Washington St. Greensboro, NC 27401 ☐ 407 E. Washington St. Greensboro, NC 27401 ☐ 1401 Long Street High Point, NC 27262 ☐ 902 Bonner Drive Jamestown, NC 27282 ☐ 401 Taylor Avenue High Point, NC 27260 ☐ 315-C White Oak St. Asheboro, NC 27203

By signing this form, I authorize FAMILY SERVICE OF THE PIEDMONT to:			
Use or Disclose to:		To Receive From:	
Agency/Person:		Agency/Person	
Address:		Address:	
Phone:		Phone:	
Person or class of persons to whom use or disclosure would be made		*Person or class of persons authorized to use or disclose information*	
The following protected health information *(Identify the information in a specific & meaningful fashion):*			
Purpose of use/disclosure:			

I understand that the health information used and disclosed may include information such as HIV infection, AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions.

RE-DISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal health 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 re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health & 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), or information collected for North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstance where disclosure is permitted or required by these laws.

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 Family Service of the Piedmont cannot deny or refuse to provide treatment on my refusal to sign, but I will be responsible for all fees that may be denied as a result of my refusal to sign.

EXPIRATION

If not revoked earlier, this authorization expires automatically upon _____ or one year from the date it is signed, whichever comes earlier.

I have read and understand the information in this authorization form and have been offered a copy:
☐ Which I accept ☐ Which I decline

Signature of Consumer:

Print Name:		Date:

OR

Signature of Authorized Representative:

Print Name:		Date:

Explain Representative's authority to act on behalf of the Consumer:	
Signature of Witness *(required if symbol or mark is used by client or representative)*	Date:

REVOCATION - Sign below **ONLY** if you are revoking your Authorization

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.) I understand I cannot stop information already released but I can stop the release of information in the future.

Signature of Consumer:		Revocation Date and Time:
Print Name:		

Therapist Name: _____