Family Service
OF THE PIEDMONT

Name: _____ **D.O.B.**: __/__/____
F.S.P.#: _____
Medicaid #: _____ **IPRS / LME #**: _____

**** PERSON REQUESTING RECORDS:** _____
**** FOR SERVICE DATE(S):** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)

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

Social Security No: (Optional)	

☐ 315 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 ☐ 308 Boulevard St. High Point, NC 27262

I, _____, authorize _____
Client name or legally responsible person *Agency or person authorized to use and disclose the information*

to use or disclose (circle one or both) to _____.
*Name of agency or person to whom the requested use or disclosure will be made (**include address / fax#**)*

THIS DATA SHALL INCLUDE *(client is encouraged to initial beside data to be used or disclosed)*

_____ Assessments _____ Service Notes _____ Substance Abuse/Treatment
_____ Psychiatric Evaluations _____ Service Plans/Goals _____ HIV/AIDS Information
_____ Discharge Summary _____ Social, Developmental, Medical History _____ Diagnoses
_____ Other: _____

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

_____ At the request of the individual _____ Assessment/Evaluation _____ Coordination of Services
_____ Court Proceedings _____ Determination of Benefits

Information requested should be mailed to this address (OUT OF STATE ONLY): _____
_____

REDISCLOSURE
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 re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health 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.

REVOCATION AND EXPIRATION
I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

_____ _____
Date of expiration, up to one year ***Event, if less than one year***

NOTICE OF VOLUNTARINESS
I understand that I may refuse to sign this authorization form. I understand that Family Service of the Piedmont will not deny or refuse to provide treatment but I will be responsible for all fees that may be denied as a result of my refusal to sign this authorization form.

_____ _____ _____
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 client:
☐ Power of Attorney ☐ Guardian
☐ Other: _____

_____
Staff Signature

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Revised 9/2020