Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **RELEASE OF INFORMATION**

I authorize Union Family Services PLLC to disclose to and/or obtain information from:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship | Phone number | Address |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

To be used for the purpose of professional case consultation and treatment coordination.

I have initialed to authorize the following information to be communicated:

|  |  |  |  |
| --- | --- | --- | --- |
| Initial |  | Initial |  |
|  | Assessment |  | Medication Management Information |
|  | Diagnosis |  | Presence/Participation in Treatment |
|  | Psychosocial Evaluation |  | Education Information |
|  | Psychological Evaluation |  | Discharge/Transfer Summary |
|  | Psychiatric Evaluation |  | Progress in Treatment |
|  | Treatment Plan or Summary |  | \*Psychotherapy Summary by Clinician |
|  | Current Treatment Update |  | Other: |

\*Psychotherapy Summary by Clinician: cannot be combined with any other type of disclosure

I specifically request that the following information be included (will not be released otherwise):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Initial |  | Initial |  | Initial |  |
|  | Drug and/or alcohol abuse |  | Sickle Cell Anemia |  | HIV/AIDS |

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Union Family Service a ufsmonroe@gmail.com or 124 Winchester Ave. Suite B, Monroe, NC 28110. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or one year/12 months from the date this document was originally signed.

##### Conditions

I further understand that Union Family Services will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: No Coordination of Care between Counselor and Physician or Other.

##### RELEASE OF INFORMATION continued

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Statutes referencing content of this form (GS122C-52 through 122C-56)

My signature below acknowledges that I authorize this release of information to the identified provider to be effective as of the date of my signature.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signing, please note relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If client or parent/guardian refuses to acknowledge receipt of above, please note here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_