Authorization for Disclosure and the Reciprocal Exchange of Information

Client Name: _____

Date of Birth: _____

I hereby request and authorize **Next Step Recovery** or contracted agent to release and exchange information to:

Person/Agency: _____ Address: _____

Phone #: _____ Fax #: _____

The following information may be released or exchanged (mark and initial all that apply):

☐ Admissions Assessment _____	☐ Discharge Summary _____
☐ Progress Notes _____	☐ Educational History _____
☐ Psychological Information _____	☐ Financial Information _____
☐ Psychiatric Information _____	☐ Insurance Information _____
☐ Substance Use Information _____	☐ Information on Prescribed Medication _____
☐ Treatment Plan and Diagnosis _____	☐ HIV/AIDS Information _____
☐ Status with Program _____	☐ Medical History _____
☐ Compliance with Program _____	☐ Other (Specify) _____ _____

Time Frame for Information to be released: _____ to _____

Once information is disclosed pursuant to this signed authorization, I understand that the federal and state privacy law (45 C.F.R. Part 160 and 164, 10A NCAC 26B.0202) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by the laws. All information and records that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions G.S. 130A-143 shall be strictly confidential.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance of the consent. In any event, if not revoked earlier, this authorization expires automatically one year (365 days) from signature date.

I understand that I may refuse to sign this authorization form. I understand that **Next Step Recovery** will begin and continue client's treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely, voluntarily, and without coercion. I understand health insurance and information, indicated by initials, will be disclosed.

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Witness: _____ Date: _____

☐ **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement requesting revocation signed and dated by the above name person or guardian.**

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Witness: _____ Date: _____