BEHAVIORAL HEALTH
Authorization for Use and Disclosure of Protected Health Information

Debbie Herman Crane, LCSW/ACSW
828-606-6024 ● 844-833-5683 (fax)
dcranelcsw@gmail.com

I, _____authorize _____
Client or Client's legal representative — Agency or person authorized to use/disclose the information

_____

to exchange with or disclose to: _____
Agency or Person to whom the requested use or disclosure will be made

_____

the following protected information: _____
Provide specific meaningful description of the information to be used/disclosed

_____

_____

_____

The purpose of this disclosure is _____
Describe purpose of the requested use or disclosure

_____

I understand information regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS or Human Immunodeficiency Virus (HIV) is safeguarded according to statute GS130A-143.

REDISCLOSURE: Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law (45CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency disclosed mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42CFR Part 2), we must inform the recipient of the information that redisclosure 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. If I revoke this authorization, I must do so in writing. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Gaston Skills Notice of Privacy Practices, a copy of which has been provided to me.

If not revoked earlier, this authorization expires upon: _____
(Not to exceed one year from date of signature)

NOTICE OF VOLUNTARY AUTHORIZATION: I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that the Behavioral Health @ Gaston Skills cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

_____ _____
Signature of Client/Legally Responsible Representative — Date

_____
Please Print Name

_____ _____
Witness — Date

Please explain representative's authority to act on behalf of client: _____

_____