Carolina Outreach
An agCARE Partner

5108 Regan Dr., Suites 13 & 14
Charlotte, NC 28206
Phone: (704) 332-8787 Fax: 332-8788
email: referrals@carolinaoutreach.com

Authorization for the Disclosure and Reciprocal Exchange of Information

Client Name: _____ Client Record #: _____

Client Date of Birth: ____/____/____ Insurance #: _____

I hereby authorize **Carolina Outreach, LLC** (5108 Regan Dr., #13 & 14, Charlotte, NC 28206) to disclose and receive specific client information about me by mail, electronic mail, fax, or other means in a reciprocal exchange of information with the following:

Person / Agency: _____

Address: _____ City: _____ State / Zip: _____

Phone: _____ Fax: _____

This data shall include (client initial by each type of information that may be released):

> Psychological Evaluation	> Diagnosis	> Alcohol / Drug Treatment*
> Psychiatric Evaluation	> Service Plan	> Hepatitis
> Screening	> Progress Notes	> Medication Information
> Client Profile	> HIV	> Financial Reimbursement
> UDS / Lab Results	> Other (please specify):	

** Client must sign, whether a child or adult; information protected by Federal Regulations 42 CFR part 2*

Purpose of the disclosure: X Assist with treatment X Referral ___ At Request of Client

___ Other: _____

I hereby acknowledge that Carolina Outreach, LLC, has not conditioned my treatment on signing this authorization, and that I may refuse to sign this authorization if I so desire. I also recognize that I retain the right to revoke this authorization except to the extent that the agency has already taken action in reliance on the consent. Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from disclosing it. North Carolina General Statutes 122C-53 through 122C56 indicate the exceptions that allow providers to break confidentiality and re-disclose records. The Carolina Outreach Client Handbook describes the circumstances where disclosure is permitted or required by state or federal laws. Other laws, however, may prohibit disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), this organization informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. In the following cases, minors have the same rights as adults and have the right to release information without a parent's signature: emancipated minors, minors receiving substance abuse treatment, and/or minors receiving treatment without parental consent. Documentation of record releases is kept in the client chart.

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

I have read this information and understand that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this authorization is truly voluntary and that I am the protected client or am authorized to act on behalf of the client to sign this document. I fully agree with the above stated terms. I understand that I may request a copy of this authorization once it has been signed.

Client/Legally Responsible Person: _____

Witness (not required): _____ Relationship to Client: _____

Date: _____

I have received a copy of this form. _____
client initials

This authorization is hereby revoked as of the date noted below:

Client / Legally Responsible Person: _____ Date: _____

The client and/or legally responsible person has notified me verbally that he/she wishes to revoke this authorization as of the date noted below:

Carolina Outreach Staff: _____ Date: _____