

Caramore Community, Inc.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

CLIENT: SOCIAL SECURITY NUMBER: DATE OF BIRTH:	The client must always be given a copy of this form after signing. Complete as needed. Use for disclosing information to other agencies or requesting information from other agencies.
---	---

I, _____, hereby authorize the release of information

TO/FROM: Caramore Community, Inc.
 550 Smith Level Road
 Carrboro, NC 27510
 (919) 942-9732 (Fax)

TO/FROM:

1.						
	Person/Agency	Street	City	State	Zip Code	Phone/Fax
2.						
	Person/Agency	Street	City	State	Zip Code	Phone/Fax
3.						
	Person/Agency	Street	City	State	Zip Code	Phone/Fax
4.						
	Person/Agency	Street	City	State	Zip Code	Phone/Fax
5.						
	Person/Agency	Street	City	State	Zip Code	Phone/Fax
6.						
	Person/Agency	Street	City	State	Zip Code	Phone/Fax
7.						
	Person/Agency	Street	City	State	Zip Code	Phone/Fax

for the purpose of (*Please Check all that apply*) admissions, treatment planning, referral, coordination of services and/or Other: _____.

Please **initial** below indicating which documentation regarding your treatment may be released and/or exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

Other Agency Documentation	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; border-bottom: 1px solid black;">Assessment/diagnoses</td> <td style="width:33%; border-bottom: 1px solid black;">Service plan(s)</td> <td style="width:33%; border-bottom: 1px solid black;">Physician's Orders/medication history</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Treatment history/plans</td> <td style="border-bottom: 1px solid black;">Medical history</td> <td style="border-bottom: 1px solid black;">Educational history</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Social/developmental history</td> <td style="border-bottom: 1px solid black;">Admission/Discharge summaries</td> <td style="border-bottom: 1px solid black;">Evaluation(s): (circle) Psychological Psychiatric Speech / OT / PT</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;">Service/Progress/Clinic note(s), dates: _____ through _____</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;">Legal History</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;">Other (specify) _____</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;"><input type="checkbox"/> Release of records is authorized even if such records contain information related to substance abuse.</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;"><input type="checkbox"/> Release of records is authorized even if such records contain information related to HIV/AIDS.</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;"><input type="checkbox"/> In addition to the initial disclosure of identified information I authorize periodic exchange of information between Caramore and the noted agencies.</td> </tr> </table>	Assessment/diagnoses	Service plan(s)	Physician's Orders/medication history	Treatment history/plans	Medical history	Educational history	Social/developmental history	Admission/Discharge summaries	Evaluation(s): (circle) Psychological Psychiatric Speech / OT / PT	Service/Progress/Clinic note(s), dates: _____ through _____			Legal History			Other (specify) _____			<input type="checkbox"/> Release of records is authorized even if such records contain information related to substance abuse.			<input type="checkbox"/> Release of records is authorized even if such records contain information related to HIV/AIDS.			<input type="checkbox"/> In addition to the initial disclosure of identified information I authorize periodic exchange of information between Caramore and the noted agencies.		
Assessment/diagnoses	Service plan(s)	Physician's Orders/medication history																										
Treatment history/plans	Medical history	Educational history																										
Social/developmental history	Admission/Discharge summaries	Evaluation(s): (circle) Psychological Psychiatric Speech / OT / PT																										
Service/Progress/Clinic note(s), dates: _____ through _____																												
Legal History																												
Other (specify) _____																												
<input type="checkbox"/> Release of records is authorized even if such records contain information related to substance abuse.																												
<input type="checkbox"/> Release of records is authorized even if such records contain information related to HIV/AIDS.																												
<input type="checkbox"/> In addition to the initial disclosure of identified information I authorize periodic exchange of information between Caramore and the noted agencies.																												

Caramore Generated Documentation	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; border-bottom: 1px solid black;">Referral/Screening Form</td> <td style="width:33%; border-bottom: 1px solid black;">Service Plan</td> <td style="width:33%; border-bottom: 1px solid black;">Physician's Orders/Medication history</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Admission Assessment</td> <td style="border-bottom: 1px solid black;">Index of Attendance</td> <td style="border-bottom: 1px solid black;">Medication Administration history</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Diagnostic Report(s)</td> <td style="border-bottom: 1px solid black;">Behavior Intervention Plans</td> <td style="border-bottom: 1px solid black;">Evaluation(s)</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;">Admission Summary</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;">Service Note(s) dates: _____ through _____</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;">Other (specify) _____</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;"><input type="checkbox"/> Release of records is authorized even if such records contain information related to substance abuse.</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;"><input type="checkbox"/> Release of records is authorized even if such records contain information related to HIV/AIDS.</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;"><input type="checkbox"/> In addition to the initial disclosure of identified information I authorize periodic exchange of information between Caramore and the noted agencies.</td> </tr> </table>	Referral/Screening Form	Service Plan	Physician's Orders/Medication history	Admission Assessment	Index of Attendance	Medication Administration history	Diagnostic Report(s)	Behavior Intervention Plans	Evaluation(s)	Admission Summary			Service Note(s) dates: _____ through _____			Other (specify) _____			<input type="checkbox"/> Release of records is authorized even if such records contain information related to substance abuse.			<input type="checkbox"/> Release of records is authorized even if such records contain information related to HIV/AIDS.			<input type="checkbox"/> In addition to the initial disclosure of identified information I authorize periodic exchange of information between Caramore and the noted agencies.		
Referral/Screening Form	Service Plan	Physician's Orders/Medication history																										
Admission Assessment	Index of Attendance	Medication Administration history																										
Diagnostic Report(s)	Behavior Intervention Plans	Evaluation(s)																										
Admission Summary																												
Service Note(s) dates: _____ through _____																												
Other (specify) _____																												
<input type="checkbox"/> Release of records is authorized even if such records contain information related to substance abuse.																												
<input type="checkbox"/> Release of records is authorized even if such records contain information related to HIV/AIDS.																												
<input type="checkbox"/> In addition to the initial disclosure of identified information I authorize periodic exchange of information between Caramore and the noted agencies.																												

PLEASE REFER TO PAGE 2 FOR FURTHER INFORMATION AND SIGNATURE(S)

Caramore Community, Inc.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

CLIENT: SOCIAL SECURITY NUMBER: DATE OF BIRTH:	The client must always be given a copy of this form after signing. Complete as needed. Use for disclosing information to other agencies or requesting information from other agencies.
---	---

I understand what information will be released, the purpose of the release of the information, and that there are statutes and regulations protecting the confidentiality of the information. Caramore's NOTICE OF PRIVACY PRACTICES describes the circumstances where disclosure is permitted or required by state or federal laws.

I understand the terms of this release and voluntarily give my authorization. I understand that I may refuse to sign this authorization form and understand that Caramore will not condition my admission or eligibility for benefits on receiving my signature on this authorization. I further understand that I may revoke my authorization by giving written or verbal notice to Caramore. Such revocation does not affect the validity of the consent for information disclosed/released prior to the revocation. If not revoked earlier, this authorization expires automatically one year from the date it is signed or upon _____, whichever is earlier.

(date or event specified by client or dictated by the purpose of the authorization)

Signed _____ Date _____
(Specify if signature is that of client, parent(s), legal guardian, or personal representative)

Witnessed _____ Date _____
(Witness signature is required only if the form is sent out of state **or** if the above client signature has been signed by a mark)

This authorization is hereby revoked upon the signed and dated request of the client as noted below:

Signed _____ Date _____
(Client signature)

The client has notified me verbally that he/she wishes to revoke this authorization with an effective date of:

Signed _____ Date _____
(Staff signature)

Federal confidentiality rules (42 CFR part 2) prohibit any further disclosure of substance abuse information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. This general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

THE INFORMATION RELEASED IS CONFIDENTIAL AND REDISCLOSURE IS PROHIBITED EXCEPT AS AUTHORIZED BY G.S. 122C-53 THROUGH G.S. 122C-56.