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:

	Person/Agency	Street	City	State	Zip Code	Phone/Fax
1.	Vocational Rehabilitation	548 Smith Level Road	Carrboro	NC	27510	(919)969-7350
2.						
3.						
4.						
5.						
6.						

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

_____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) _____
_____Release of records is authorized even if such records contain information related to substance abuse.
_____Release of records is authorized even if such records contain information related to HIV/AIDS.
_____In addition to the initial disclosure of identified information I authorize periodic exchange of information between Caramore and the noted agencies.

Caramore Generated Documentation

_____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) _____
_____Release of records is authorized even if such records contain information related to substance abuse
_____Release of records is authorized even if such records contain information related to HIV/AIDS.
_____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)

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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.