ALASE Center for Enrichment II

Helping to Heal Minds, Hearts and Souls

CLIENT: RECORD 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. In the following cases, minors have the right to release information without parent's signature; these minors have the same rights as adults: 1. Emancipated minors 2. Minors receiving Substance Abuse treatment 3. Minors receiving treatment without parental consent.

RECIPROCOL RELEASE OF INFORMATION

I, [print name] ______________________________, hereby authorize the release of information

☐ **TO** ☐ **FROM: ALASE CENTER FOR ENRICHMENT II**
(Please Check)

☐ **TO** ☐ **FROM:** ______________________________
(Please Check) Person/Agency

FOR THE PURPOSE OF: ☐ Assessment, ☐ Treatment Planning, ☐ Referral, and/or ☐ Coordination of Services.

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.

DOCUMNETATION REQUESTED

______ Assessment/diagnoses	______ Service plan(s)	______ Physician's Orders/medication history
______ Treatment history	______ Medical history	______ Educational history
______ Social/developmental history	______ Discharge summary	______ Evaluation(s): ____________

______ 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 verbal exchange of information **ALASE** and the noted agencies.

I understand the federal privacy law regarding the protection of substance abuse information per the confidentiality and disclosure requirements of 42 CFR Part 2 and the requirements for protection of HIV/AIDS information under G.S. 130A-143; however, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.

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. **ALASE'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 **ALASE** will not condition my treatment, or any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this authorization.

I further understand that I may revoke my authorization by giving written notice to **ALASE.** 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 <u>or</u> if the above client signature has been signed by a mark)

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