C JAN KRAUSE

C Jan Krause Counseling PLLC

Authorization for Release/Exchange of Medical Record Information

CLIENT FIRST AND LAST NAME: _____DATE OF BIRTH:_____

1. AUTHORIZATION TO RELEASE, SHARE AND EXCHANGE INFORMATION BETWEEN C. JAN KRAUSE COUNSELING AND THE FACILITIES/INDIVIDUAL LISTED BELOW

Name of Person: C Jan Krause, MACMH
Agency: C. Jan Krause, PLLC
Address: 306 West Franklin, Suite F Chapel Hill, NC 27515
Phone: 919.299.6264
Email: jan@cjankrause.com

Name of Person to contact and/or Agency: _____
Address and Phone: _____

2. Information to be released, shared, and exchanged:

Note: Once authorization is completed, it cannot be altered in any way. If a client wishes to alter this authorization it must be revoked, and a new authorization completed.

_____ Program Goals _____ Medication Information _____ Comprehensive Clinical Assessment
_____ Program Progress _____ Medical Information

3. Purpose of the release: (*initials)* _____ Continuation of Care

Other : _____

4. I understand that my information may not be protected from re-disclosure by the requester/recipient of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (CFR 42, part 2), and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 CFR, part 160 & 164 the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.
5. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.
6. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to services
7. I understand that consent to release information to the NC Division of Motor Vehicles, the Department of Corrections, or the NC Court System for the purpose of reinstatement of a motor vehicle license is valid until driving privileges are reinstated. (10 NCAC 18D .0208)
8. I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose or for up to one year from the signature date. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.
9. I further understand I will be given a copy of this form once this authorization has been dutifully completed.

_____
Signature of Client Date Signed Expiration Date

_____
Signature of Legal Representative Relationship to Youth Date Signed Expiration Date

▫ **Authorization Revoked**
Signature and Date: _____