MUTUAL EXCHANGE OF INFORMATION

RESILIENT JOURNEYS, PLLC

María S. White, MSW, LCSW, LCAS. RYT500

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I hereby give my permission for a mutual exchange of information between
RESILIENT JOURNEYS, PLLC, María S. White, MSW, LCSW, LCAS, RYT500 and the Name listed below:

Name/Organization: _____
Address _____
_____
_____
Phone _____
Fax _____

Concerning the treatment of the person listed below:

Client Name _____ Date of Birth: _____
Insurance _____
Address _____
_____
Phone _____

For the purpose of the items initialed below:

___ Confirmation of diagnosis ___ Medications ___UDS and breathalyzer results
____ Mental Health/Substance Abuse Assessments ___Progress reports/discharge summary
___ On-going Coordination of Services ___ Insurance ___Emergency Contact __Treatment Plans/SO
____messages for appts.___ Other, as specified _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and, if not revoked sooner in writing, this consent will expire 365 days from the day signed. I understand that I have the right to receive a copy of this consent. (Please refer to your Services Agreement for exceptions to your treatment confidentiality.)

"42CFR 2.12 (2) Restriction on use. The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290ee-3(c), 42 U.S.C. 290dd-3(c)) applies to any information, whether or not recorded which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date), for the purpose of treating alcohol or drug abuse, making a diagnosis for the treatment, or making a referral for the treatment. Information relative to AIDS or any related condition is disclosed only in accordance with the communicable disease laws as specified in G.S.130A-143.NC General Statue 130A-12 states that "All records containing privileged patient medical information that are in the possession of the agency shall be confidential and shall not be public records pursuant to General Statutes 132- 1." However, "Notwithstanding G.S. 8-53 or G.S. 130A-143, the information contained in the records may be disclosed for purposes of treatment, payment, or health care operations," as defined by the HIPAA Privacy Rule

Release or transfer of the above information to any other person or organization is prohibited without an additional written consent authorizing such a transfer.

Client Name_____
(*Please print*)

Client Signature_____ Date_____

Parent/Guardian Name_____
(*Please print*)

Parent/Guardian Signature_____ Date_____

Witnessed by _____ Date_____