NO LIMITS RESIDENTIAL CARE LLC

“WE DON’T TEACH LIMITS HERE — WE TEACH POTENTIAL.”

FORM 3 — CONSENT FOR RELEASE OF INFORMATION

Client Name: _____
Date of Birth: _____
Record Number: _____

SECTION 1 — PURPOSE OF THIS CONSENT
This authorization allows No Limits Residential Care LLC to obtain, release, and exchange information necessary for treatment coordination, mental and medical care, educational planning, safety monitoring, behavioral health collaboration, and continuity of care.

SECTION 2 — PARTIES AUTHORIZED TO SHARE INFORMATION
A. Medical Providers:
• Primary care physicians
• Hospitals, urgent care, specialists
• Dental providers

B. Mental & Behavioral Health Providers:
• Psychiatrists, psychologists
• Therapists, counselors
• Crisis response teams

C. Educational Entities:
• Schools and districts
• EC/IEP teams (information exchange only)
• School nurses or social workers

D. Case Management & Legal Entities:
• DSS/Child Protective Services
• Guardian ad Litem
• MCO/Care coordination
• Court-appointed representatives

E. Other Agencies:

• Prior placements
• Relevant service providers

SECTION 3 — INFORMATION COVERED BY THIS RELEASE
• Diagnosis, treatment summaries, behavioral observations
• Psychiatric evaluations, medication details
• Medical/dental records and immunization history
• School records and attendance
• Crisis plans, incident reports
• Intake assessments and discharge plans

SECTION 4 — CONFIDENTIALITY PROTECTIONS
All information follows HIPAA, FERPA, 42 CFR Part 2 (when applicable), and NC DHHS Residential standards. No Limits will not share information with unauthorized parties unless required by law or safety.

SECTION 5 — EXPIRATION & REVOCATION
Valid for 1 year, until revoked in writing, or until discharge. Revocation does not affect information already released in good faith.

SECTION 6 — SIGNATURES
Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:** _____

Staff Witness Signature: _____ **Date:** _____