United Quest Care Services, LLC

"Providing Effective Cultural & Competent Care"

CONSENT FOR RELEASE OF CLIENT INFORMATION

To Permit Use and Disclosure of Health Information

This authorization from implements the requirements for consumer authorization to use and disclose Health Information protected by the Federal Privacy Law, (HIPPA) 45 C.F.R. parts 160-164; the Federal Confidentiality Law, 42 C.F.R. part 2, and state Confidentiality Law governing Mental Health, Developmental Disabilities, and Substance Abuse Services G.S. 122 C.

Consumer:	DOB:
Record Number:	SSN:

Requests and authorizes, United Quest Care Services, LLC to use or disclose the Protected Health Information indicated below (including HIC & Substance related information is applicable) to:

Contact: _____Relationship:_____

Phone Number:_____

Please indicate information to be disclosed:

_____ Admission/Screening Assessment	_____ Service Plan	_____ Service Note
_____ Medication HX Physicians	_____ Psychological testing	_____ HIV Related Info
_____ Discharge Information	_____ Substance Abuse Info	_____ Psychiatric Eval
_____ 3rd Party Info	_____ Accounting of Disclosure	_____ 508 DWI Form

Other Information (if not listed):_____

Purpose of disclosures: _____ Continuity of Care _____ Referral _____ Legal _____ Service delivery _____ Other_____

- I understand that the health information used and disclosed may include information such as HIV infection, AIDS-related conditions, alcohol abuse, drug abuse and psychological or psychiatric conditions. I authorize release of information regarding HIC or AIDS-related conditions. (HIV or other communicate disease related Information may be a part of multiple documents in the record.)
- I understand that once information is disclosed pursuant to this Authorization, it is possible that it will not be protected by state and federal privacy and confidentiality laws and that it could be re-disclosed by the person or agency that receives it.
- I understand that by indicating I authorize 3rd Party Information to be disclosed, any Protected Health Information (PHI) from other treatment facilities contained in this medical record will be shared pursuant to this authorization, including substance abuse information.
- I understand with certain exceptions; I have the right to revoke this authorization at any time (orally or by submission of written notification). This procedure for revoking authorizations as well as the exceptions to my right to revoke is explained in United Quest Care Services, LLC Notice of Privacy Practices. If you do not have the Notice of Privacy Practices, you may request one from the receptionist.
- The meaning of this authorization form has been explained to me. I understand that I may refuse to sign this authorization form. I understand that United Quest Care Services, LLC will not condition treatment on receiving my signature on this authorization. I understand this authorization is made freely, voluntary and without coercion. I understand the Health Information indicated will be disclosed per my instructions.

This authorization is effective only for the following period of time (not to exceed 12 months)

From: _____ To: _____

My authorization is withdrawn if any of the following occur: Event:_____
_____

Signature of Consumer/Guardian:	Date:
Witness:	Date: