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| **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  \_\_\_\_\_\_\_Treatment history  \_\_\_\_\_\_\_Social/developmental history | \_\_\_\_\_\_\_\_\_Service plan(s)  \_\_\_\_\_\_\_\_\_Medical history  \_\_\_\_\_\_\_\_\_Discharge summary | | \_\_\_\_\_\_\_\_Physician’s Orders/medication history  \_\_\_\_\_\_\_\_Educational history  \_\_\_\_\_\_\_\_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 **or** if the above client signature has been signed by a mark)  6015 Fayetteville Road, Suite #114, Durham, NC 27713  Office: (919) 957-7357 www.alase.net Fax: (919) 957-9539 | | | | |



ALASE Center for Enrichment II

Helping to Heal Minds, Hearts and Souls