S&H Youth and Adult Services, Inc.
714 S Main St Salisbury NC 28144
5736 N Tryon Charlotte NC 28213
SHYAS.COM | 866-495-3651 | 704-353-7901

SHYAS
Your Place of Security & Hope

Consent to Release or Exchange of Consumer Information

Name, Address, & Phone Number of Agency, Organization or Individual Requesting Release	Name, Address, & Phone Number of Agency, Organization or Individual Releasing information (i.e. primary care, psychiatrist, previous Treatment provider, natural supports, school)
S&H Youth and Adult Services, Inc. Inc.	
714 South Main Street Suite 208	
Salisbury NC 28144	
Phone: 704-603-8285 Fax: 704-353-7901	

I understand that the information released may include information regarding HIV/AIDS information. I consent to the above-named agencies, organization or individuals to release, exchange, and/or communicate with one another the information that is listed below for the purposes of Coordination of Care

This data shall include: (Client must initial all that apply)
☐Screening and/or Admission Assessment Evaluation
☐ Treatment (Service) Plan I Diagnosis
☐ Discharge Summary
☐ Case Management Assessment / Plan
☐Psychiatric and or Psychological Evaluation
☐ Progress (Service) Notes: Dates from _____to_____
☐ Treatment report from other agencies / persons (specify): _____
☐ Medication History
☐ Other:_____

Client must initial if any of the above data contains substance abuse information:

_____ I understand that my records are protected under the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. 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. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be
denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

_____ I understand this information will be used for the development of individual services provided by community support professional and adjunct/partnering agencies used as community resources to meet my individual needs. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent will terminate upon _____(mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

_____ _____
Consumer or Legally Responsible Person Date

_____ _____
Consumer or Legally Responsible Person Date

NOTE: In case of minor receiving substance related services, the minor must always sign the Consent for Release of Information, and when applicable, the legally responsible person

AUTHORIZATION REVOCATION

_____ I hereby choose to revoke this consent and request that it no longer be valid as of this date: ___/___/___

CONSUMER NAME:	INSURANCE/MEDICAID ID#:	D.O.B. :	RECORD#: