Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

Consent Forms: (p.1)

_____ (Initial here once informed) **Restrictive Interventions**

I, give permission to the above mentioned agency to perform restrictive intervention on when all other methods have been exhausted when trying to deescalate the above mentioned consumer. Following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with to eliminate or reduce the probability of the future use of restrictive interventions. I understand that this consent is only valid for unplanned restrictive interventions and is not invalid unless the client or legally responsible person chooses to withdraw the consent.

_____ (Initial here once informed) **Suspension and Expulsion from Service**

I , understand the if I do not comply with the rules outlines by the agency and becomes a possible threat to others served within this agency he/she maybe possibly suspended or expulsed from services. I understand that this would be the agency's last result before assessing the client to see if he/she meets the criteria to discharge. However, if it results in discharge the agency will follow its due process procedure before exhausting all other means.

_____ (Initial here once informed) **Search and Seizure**

I understand that each client shall be free from unwarranted invasion of privacy. However, I understand that searches of me/my child's living area may occur. I, also give permission to the agency to perform random planned or unplanned searches and seizures on me/my child's belongings, or property in his/her possession. I understand that each search will be documented to include; scope of search, reason for search, procedures followed in the search, description of any property found and an account of the disposition of seized property.

_____ (Initial here once informed) **Carolina Legal Assistance**

I understand a written summary of client rights shall be made available to each client and legally responsible person. I have been informed of his/her right to contact The Carolina Legal Assistance or any statewide advocacy agency designated under federal and state law to protect and advocate the rights of person with disabilities.

_____ (Initial here once informed) **Admissions into Services Agreement**

I understand that I shall be informed of services rendered by this agency upon admission or entry into services.

_____ (Initial here once informed) **Agency Rules**

I understand the rules that I am/my child is expected to follow and possible penalties for violation of the rules.

_____ (Initial here once informed) **Consent regarding Disclosure of Confidential Information**

I understand that the agency will follow its policy as it relates to protecting my rights regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56.

_____ (Initial here once informed) **Consent regarding Treatment**

I give permission to **Precious Haven, Inc** to provide me / my child with the necessary treatment I need that will assist me with my problems/issues. I understand that in order for **Precious Haven, Inc.** to assist me / my child with meeting my/our needs that **Precious Haven, Inc.** will generate a Habilitation plan and/or other information that relates to me/my child in order for the agency to adequately serve.

_____ (Initial here once informed) **Fee Assessment**

I understand that I will be responsible for fees assess by my/my child that Medicaid and/or the Division of Medical Assistance does not cover as it relates to the treatment of me/my child. I understand that the agency will do everything possible to avoid collection from me/my child on behalf of treatment/habilitation services rendered.

_____ (Initial here once informed) **Consumer Choice Agreement**

I have received information regarding services which I am eligible to receive. I have been informed of providers from whom I am eligible to receive such services. Based upon this information, I have made an informed choice of the services and providers. I, understand that by completing and signing this form, I choose, ***Precious Haven, Inc.*** as my services provider.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

(Date of expiration, if less than one year) (Event, if less than one year)

_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client)

_____ _____
Signature of legally responsible person Date

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

Consent Form (P. 2)

_____ (Initial here once informed) **Grievance Procedures**

I understand that I/my child has the right disclose any grievances that he/she may have as it relates to the agency. I understand that **Precious Haven, Inc.** will be provided a description of the assistance that the agency will be provided. I understand that the agency will be provided the results of any grievance submitted on behalf of my/my child. I understand that he/she will be given a chance to dispute the results of his/her grievance if the findings are not to his/her satisfaction. I understand that I can contact Carolina Legal Assistance who replaced (GACPD)/or the Local Mental Health LME.

_____ (Initial here once informed) **Informed of Client Rights**

I understand and have been informed and received a copy of the Client Rights handbook. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent. I have received, and had been explained my Rights to Privacy. **Precious Haven, Inc.** gave me a copy of the Client Rights handbook and I understand these rights which are designed to protect the privacy of me/ and/or my child.

_____ (Initial here once informed) **Social Integration**

I give **Precious Haven, Inc.** my permission to allow me/my child to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. I /my child shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62 (e).

_____ (Initial here once informed) **Emergency Medical Treatment**

I give **Precious Haven, Inc.** my permission to seek emergency care for me/my child from a hospital or physician. I also give **Precious Haven, Inc.** the consent to seek and sign consent for preventive and emergency medical care for my child in my absence. It is understood that **Precious Haven, Inc.** will attempt to contact me, or another designated responsible adult as soon as possible in the event of an emergency.

_____ (Initial here once informed) **Disaster and Risk Management Plan**

I have been informed and received a copy **Precious Haven, Inc.** Disaster Preparedness Plan and Risk Management Practices. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent.

_____ (Initial here once informed) **Financial Release**

I have been informed and received a copy **Precious Haven, Inc.** may use confidential information about me to bill and be paid for services. I hereby consent **Precious Haven, Inc.** to release information to Value Options (the State of NC managed care vendor) and/or the referring Area Program.

_____ (Initial here once informed) **Transport**

I have been informed and received a copy **Precious Haven, Inc.** to provide transportation to my child, and agree to hold **Precious Haven, Inc.** harmless for any accident/injury that results from the provision of transportation.

_____ (Initial here once informed) **Suicidal Contract**

I promise not to harm or injure myself in any way for the time in which I am receiving services through **Precious Haven, Inc.** I understand that at any point I start to feel like harming myself, I will contact the (Precious Haven, Inc. Crisis Line (910) 308-6067) or go to the nearest emergency department for help.

_____ (Initial here once informed) **AIDS/HIV consent statement**

I understand that it shall not be unlawful for a health care provider to: (1) treat a person who has AIDS virus or HIV infection HIV/AIDS differently from persons who do not have that infection when such treatment is appropriate to protect the health care provider or employees of the provider or employees of the facility while providing appropriate care for the person who has the AIDS virus or HIV infection; or HIV/AIDS. (2) Refer a person who has AIDS virus or HIV infection HIV/AIDS to another licensed health care provider or facility when such referral is for the purpose of providing more appropriate treatment for the person with AIDS virus or HIV infection.HIV/AIDS."

_____ (Initial here once informed) **Photo Consent**

I grant permission to Precious Haven, Inc. to obtain and maintain a copy of my photograph (i.e. Identification card, driver's license or any form of photo id) may be included as part of my medical record for identification purposes. I understand that my images will be stored in a secure location and only authorized staff will have access to them.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

(Date of expiration, if less than one year) (Event, if less than one year)

_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client)

_____ _____
Signature of legally responsible person Date

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

FACE SHEET/ADMISSION/SCREENING / REFERRAL FORM

Precious Haven, Inc. 2936 Breezewood Avenue Fayetteville, NC 28303	North Carolina Division Of Mental Health, Developmental Disabilities, and Substance Abuse Services
Address Directions:	Referral Source: ☐ **Self/Walk-in** ☐ **Unreported** Name:
Home telephone # : OK to call: ☐ Yes ☐ No ( )	Relationship:
Cell telephone #: OK to call: ☐ Yes ☐ No ( )	Service status (check open or closed): ☐**Open** ☐LME ☐ Other provider Case Manager's name:
	☐**Closed** ☐ Previous services
Parent/ Legal guardian information: ☐ **Unreported** Name:	Emergency contact:☐ Unreported Name:
Street:	Street:
City: State:	City: State:
Zip code: Telephone #: ( )	Zip code: Telephone #:( ) Relationship:
Medical History or Treatment Physician: Name/Practice:	Court status: ☐ None ☐ Court ordered ☐ Court involved ☐ In custody
Address:	Probation Officer: ☐ **Unreported** Name:
Telephone #:	Telephone #:( )

PRESENTING PROBLEM & DIAGNOSIS (IF KNOWN)

Diagnosis Information:
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V: GAF Score: Locus Score:

(USE REVERSE SIDE FOR ADDITIONAL SPACE)

BARRIERS TO CARE: ☐ None EXPLANATION REQUIRED FOR: ☐ Physical ☐ Language ☐ Cultural ☐ Transportation ☐ Other

CLINICAL STATUS (CHECK ONE): ☐ EMERGENT (2HRS) ☐ URGENT (48 HOURS) ☐ ROUTINE (7 DAYS)

APPOINTMENT INFORMATION	INSURANCE
DATE: TIME: ☐AM ☐ PM	☐ None ☐ Medicaid ☐ Medicare ☐ BCBS ☐ Tricare ☐ United Health Care ☐ Mailhandlers' ☐ Other (Specify) IPRS State Funds SEE REVERSE SIDE FOR ADDITIONAL INSURANCE INFORMATION
LOCATION: ☐ BAC ☐ EP ☐ OTHER:	
PROVIDER:	
LME AUTHORIZATION NUMBER:	

INSURANCE COMPANY INFORMATION

NAME:	Policy Number:
Issue Date:	Expiration Date:

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

I, _____ authorize _____***Precious Haven, Inc.***_____**to** use or disclose to with _____ _Alliance Behavioral Healthcare _____
(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to **initial** beside data to be used or disclosed)

____ Assessments _____ Service Notes ___ Substance Abuse/Treatment ___ School Records
____ Psychiatric Evaluations _____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis _____ Discharge Summary ___ Social History
____ Developmental History _____ Financial/Reimbursement ___ Medical History
_____ PCP _____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
____ At the request of the individual _____ Assessment/Evaluation
_____ Coordination of Service ____ Court Proceedings _____ Determination of Benefits

Information requested should be mailed to this address: **2936 Breezewood Avenue Fayetteville, NC 28303**

Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S. 130A-143. Whenever authorization is required for the release of this information, the consent shall specify that the information to be released includes information relative to HIV infection, AIDS or AIDS related conditions

REDISCLOSURE:
Since information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 and 164) 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. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:
I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the agency's Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

(Date of expiration, if less than one year) (Event, if less than one year)

Notice of Voluntariness:
I understand that I may refuse to sign this authorization form. I understand that **Precious Haven, Inc.** will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

_____ _____
Signature of legally responsible person Date

Please explain LRP authority to act on behalf of the client: _____
___ Power of Attorney ____ Guardian Staff Signature
___ Other: _____

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

I, _____ authorize _____***Precious Haven, Inc.***_____**to** use or disclose to with _____ __Division of Medical Assistance_____
(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to **initial** beside data to be used or disclosed)

____ Assessments _____ Service Notes ___ Substance Abuse/Treatment ___ School Records
____ Psychiatric Evaluations _____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis _____ Discharge Summary ___ Social History
____ Developmental History _____ Financial/Reimbursement ___ Medical History
_____ PCP _____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
____ At the request of the individual _____ Assessment/Evaluation
_____ Coordination of Service ____ Court Proceedings _____ Determination of Benefits

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_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

_____ _____
Signature of legally responsible person Date

Please explain LRP authority to act on behalf of the client: _____
___ Power of Attorney ____ Guardian Staff Signature
___ Other: _____

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

I, _____ authorize ***Precious Haven, Inc.*** **to** use or disclose to with
_____ Department of Health and Human Services_____
(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to **initial** beside data to be used or disclosed)

____ Assessments _____ Service Notes ___ Substance Abuse/Treatment ___ School Records
____ Psychiatric Evaluations _____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis _____ Discharge Summary ___ Social History
____ Developmental History _____ Financial/Reimbursement ___ Medical History
_____ PCP _____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
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REVOCATION AND EXPIRATION:
I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the agency's Notice of Privacy Practices, a copy of which has been given to me.

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_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

_____ _____
Signature of legally responsible person Date

Please explain LRP authority to act on behalf of the client: _____
___ Power of Attorney ____ Guardian Staff Signature
___ Other: _____

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

I, _____ authorize _____ ***Precious Haven, Inc.*** _____ **to** use or disclose to with _____ Emergency Contact Person: _____
(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to **initial** beside data to be used or disclosed)

____ Assessments _____ Service Notes ___ Substance Abuse/Treatment ___ School Records
____ Psychiatric Evaluations _____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis _____ Discharge Summary ___ Social History
____ Developmental History _____ Financial/Reimbursement ___ Medical History
_____ PCP _____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
____ At the request of the individual _____ Assessment/Evaluation
_____ Coordination of Service ____ Court Proceedings _____ Determination of Benefits

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REVOCATION AND EXPIRATION:
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(Date of expiration, if less than one year) (Event, if less than one year)

Notice of Voluntariness:
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_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

_____ _____
Signature of legally responsible person Date

Please explain LRP authority to act on behalf of the client: _____
___ Power of Attorney ____ Guardian Staff Signature
___ Other: _____

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

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I, _____ authorize _____***Precious Haven, Inc.***_____**to** use or disclose to with _____ _Primary Care Physician: _____
(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to **initial** beside data to be used or disclosed)

____ Assessments _____ Service Notes ___ Substance Abuse/Treatment ___ School Records
____ Psychiatric Evaluations _____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis _____ Discharge Summary ___ Social History
____ Developmental History _____ Financial/Reimbursement ___ Medical History
_____ PCP _____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
____ At the request of the individual _____ Assessment/Evaluation
_____ Coordination of Service ____ Court Proceedings _____ Determination of Benefits

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REDISCLOSURE:
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REVOCATION AND EXPIRATION:
I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the agency's Notice of Privacy Practices, a copy of which has been given to me.

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_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

_____ _____
Signature of legally responsible person Date

Please explain LRP authority to act on behalf of the client: _____
___ Power of Attorney ____ Guardian Staff Signature
___ Other: _____

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

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I, _____ authorize _____ ***Precious Haven, Inc.*** _____ **to** use or disclose to with _____ DSS: _____ _____
(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to **initial** beside data to be used or disclosed)

____ Assessments _____ Service Notes ___ Substance Abuse/Treatment ___ School Records
____ Psychiatric Evaluations _____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis _____ Discharge Summary ___ Social History
____ Developmental History _____ Financial/Reimbursement ___ Medical History
_____ PCP _____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
____ At the request of the individual _____ Assessment/Evaluation
_____ Coordination of Service ____ Court Proceedings _____ Determination of Benefits

Information requested should be mailed to this address: **2936 Breezewood Avenue Fayetteville, NC 28303**

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_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

_____ _____
Signature of legally responsible person Date

Please explain LRP authority to act on behalf of the client: _____
___ Power of Attorney ____ Guardian Staff Signature
___ Other: _____

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

I, _____ authorize _____ ***Precious Haven, Inc.*** _____ **to** use or disclose to with _____ Probation Officer: _____
(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to **initial** beside data to be used or disclosed)

____ Assessments _____ Service Notes ___ Substance Abuse/Treatment ___ School Records
____ Psychiatric Evaluations _____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis _____ Discharge Summary ___ Social History
____ Developmental History _____ Financial/Reimbursement ___ Medical History
_____ PCP _____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
____ At the request of the individual _____ Assessment/Evaluation
_____ Coordination of Service ____ Court Proceedings _____ Determination of Benefits

Information requested should be mailed to this address: **2936 Breezewood Avenue Fayetteville, NC 28303**

Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S. 130A-143. Whenever authorization is required for the release of this information, the consent shall specify that the information to be released includes information relative to HIV infection, AIDS or AIDS related conditions

REDISCLOSURE:
Since information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 and 164) 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. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:
I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the agency's Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

(Date of expiration, if less than one year) (Event, if less than one year)

Notice of Voluntariness:
I understand that I may refuse to sign this authorization form. I understand that **Precious Haven, Inc.** will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

_____ _____
Signature of legally responsible person Date

Please explain LRP authority to act on behalf of the client: _____
___ Power of Attorney ____ Guardian Staff Signature
___ Other: _____

Precious Haven, Inc.

Client Name: **Date of Birth:** **Gender:**
Address: **MID#:** **Medical Record #:**

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

I, _____ authorize _____ ***Precious Haven, Inc.*** _____ **to** use or disclose to with

_____

(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to **initial** beside data to be used or disclosed)

____ Assessments _____ Service Notes ___ Substance Abuse/Treatment ___ School Records
____ Psychiatric Evaluations _____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis _____ Discharge Summary ___ Social History
____ Developmental History _____ Financial/Reimbursement ___ Medical History
_____ PCP _____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
____ At the request of the individual _____ Assessment/Evaluation
_____ Coordination of Service ____ Court Proceedings _____ Determination of Benefits

Information requested should be mailed to this address: **2936 Breezewood Avenue Fayetteville, NC 28303**

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