

Client: _____

Record Number: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

General Release

Date of Birth _____

Client SS # _____

I _____ hereby authorize

(Client or Personal Representative)

Piedmont Behavioral Healthcare (pbH)

(Name of Provider/Plan)

to disclose/exchange specific health

information from the records of the above named client to/from _____

(Recipient Name/Address/Phone/Fax)

for the specific purpose(s):

Specific information to be disclosed:

I understand that this authorization will expire on the following date, event or condition: _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

PIEDMONT BEHAVIORAL HEALTHCARE
CABARRUS, ROWAN, STANLY AND UNION COUNTIES

NORTH CAROLINA DIVISION OF MENTAL
HEALTH, DEVELOPMENTAL DISABILITIES
AND SUBSTANCE ABUSE SERVICES

Client:

Record Number:

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 further understand that I may request a copy of this signed authorization.

Signature of Client *Date* *Witness (required only when signature is 'X', mark or symbol)*

Signature of Personal Representative *Date* *Personal Representative Relationship/Authority*

REVOCACTION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding. _____
(Signature of Staff) *(Date)*

(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on *(Date)* _____. The client or his personal representative has been informed that any action taken on this authorization prior to the rescinded date is legal and binding.

(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*

