Local Contact Agency
Consent for the Release of Confidential Information

I, ______________________________________________ authorize,

NAME OF CLIENT

______________________________________________________
NAME OR GENERAL DESIGNATION OF FACILITY MAKING DISCLOSURE

to disclose to _________________________________________ the following information:

NAME OF LOCAL CONTACT AGENCY TO WHICH DISCLOSURE IS TO BE MADE

______________________________________________________
NATURE AND AMOUNT OF INFORMATION TO BE DISCLOSED, AS LIMITED AS POSSIBLE

The purpose of the disclosure authorized in this consent is to:

______________________________________________________
PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

______________________________________________________
SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law.

I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

________________________________    __________________
Signature of Client            Date

________________________________________ __________________
Signature of person signing form if not client             Date

Describe authority to sign on behalf of client ____________________________________

________________________________    __________________
Witness                          Date

North Carolina Department of Health & Human Services  |  Division of Aging and Adult Services
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