AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

Mecklenburg County
Community Support Services

_____
Agency Address

_____
City, State Zip

This form implements the requirements for client authorization to use and disclose health 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 state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

Consumer's Name	Social Security #	Medical Record ID	Date of Birth

I, the above-named person, authorize Mecklenburg County Community Support Services Substance Use Services and the following party:

Name:

Address

to communicate with and disclose to one another the following information (dated from _____ to _____).

_____
Provide a specific and meaningful description of the information to be used and disclosed

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

PURPOSE OF USE & DISCLOSURE

The purpose of the disclosure is _____
Describe each purpose of the requested use or disclosure

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses 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 redisclosure is prohibited except as permitted or required by these two laws.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. [If I want to revoke this authorization, I must do so in writing.] The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in Mecklenburg County's Notice of Privacy Practices, a copy of which has been provided to me.

If not revoked earlier, this authorization expires automatically upon_____
Date or event that relates to the consumer or the purpose of the use or disclosure

Or one year from the date it is signed, whichever is earlier.

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand Mecklenburg County Provided Services Organization cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign.

SIGNATURES

Signature of consumer: _____ Date_____

Please print name: _____

Signature of legally responsible person or other personal representative (if required): _____ Date_____

Please print name: _____

Please explain representative's authority to act on behalf of consumer: _____

_____