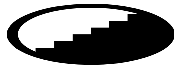
**S.T.E.P's Developmental Academy, Inc.**



# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (445 C.F.R. parts 160, 164), the federal drug and alcohol 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

____________________________________________________________, to use or disclose to

*Agency/person releasing information & Address (if needed)*

______________________________________________________________________

*Agency or person to whom the requested use or disclosure will be made & Address (if needed)*

the following protected information (dated from _______to_______) historical, psychological, medical, social, vocational, educational, and behavioral data.

**THIS DATA SHALL INCLUDE** *(client must initial beside data to be used or disclosed)*

____Assessments
____Psychiatric Evaluations
____Psychological Evaluations
____Diagnosis
____Service Notes
____Service Plans/Goals
____Discharge Summary
____Financial/Reimbursement
____Substance Abuse/Treatment
____HIV/AIDS Information
____Social, Developmental, Medical History
____Other______________________________________________________________

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 immune deficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immune deficiency 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 re-disclosing it. Other laws, however, may prohibit re-disclosure. 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 re-disclosure 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 S.T.E.P's Developmental Academy, Inc.'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 that S.T.E.P's Developmental Academy, Inc. 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:________________________

______________________________________________________________________