ALBEMARLE MENTAL HEALTH CENTER

CONSENT FOR RELEASE OF CLIENT INFORMATION

CLIENT NAME: _____CLIENT RECORD #: _____
CLIENT DOB: _____CLIENT SS NUMBER: _____

This authorization form implements the requirement s for client authorization to use and disclose health information protected by the federal health privacy law, 45 CFR Parts 160, 164; the federal drug and alcohol confidentiality law, 42 CFR, Part 2; and state confidentiality law governing mental health, developmental disabilities and substance abuse services GS 122C

I,_____, request and authorize, Albemarle Mental Health Center, managed by East Carolina Behavioral Health, 144 Community College Road, Ahoskie, North Carolina 27910, to release/receive specified information concerning me for use and/or disclosure to/from Dare County Sheriff's Department, 962 Marshall C. Collins, Drive, Manteo, North Carolina 27954.

The data to be released/received may include the following protected information: (please specify)

__X__ History & Physical
__X__ Diagnosis
__X__ Current Medications
__X__ Screening Assessment
__X__ Psychiatric Evaluation
__X__ Involuntary/Voluntary Commitments
__X__ Lab Work/EKG
__X__ Discharge Summary
__X__ Service Plan/Treatment Plan
__X__ Progress Notes
__X__ Psychological/Psycho-Ed Testing
__X__ Provider Referral Information

*** The following items must be initialed to be included in the use or disclosure of other health information:**

__X__ *DWI information required for reinstatement of driving license/privilegesPLEASE INITIAL**
_____ *HIV/AIDS related health information/records
__X__ *Drug/alcohol diagnosis, treatment and/or referral information **PLEASE INITIAL
_____ *Urine drug screen results

Describe: (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the redisclosure of such information).

_____
_____

__X__ Other: Application for concealed handgun permit

PURPOSE OF USE AND DISCLOSURE

The purpose of the disclosure is:

__X__ Evaluation for concealed handgun permit

This consent includes information to be exchanged in verbal, written or electronic form.

CONTINUED ON BACK SIDE

CLIENT NAME: _____ CLIENT RECORD #: _____

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 CFT,Part 164) protecting health information may not apply to the recipient of the information and, therefore, 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 we disclose mental health and developmental disabilities information protected by state law (GS 122C) or substance abuse treatment information protected by federal law (42 CFR, Part 2), we must inform the recipient of the information that redisclosure is prohibited except circumstances where disclosure is permitted or required by these laws.

REVOCATION and EXPIRATION

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. In any event, if not revoked earlier, this authorization expires automatically one year from the date it is signed. Revocation of this authorization must be done in writing to the Privacy Officer at 252-332-4137 or completion of the Revocation Authorization Form.

I understand that I may refuse to sign this authorization form. I understand that AMHC/ECBH will not condition the client's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this authorization.

NOTICE of VOLUNTARINESS

This consent has been explained to me and I understand its contents and the need for information to be released. I further understand there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such requested is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

SIGNATURES

Signature of Client: _____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 client: (relationship)
_____