Shelby Wellness & Therapy Center PLLC
809 N. Lafayette Street STE A
Shelby NC 28150
704-284-0554

NC Division of Mental Health,
Developmental Disabilities,
Substance Abuse Services

AUTHORIZATION FOR USE AND DICLOSURE OF PROTECTED HEALTH INFORMATION

45 C.F.R., Parts 160 and 164; 42 C.F.R. Part 2; G.S.122C

This authorization 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. 122 C).

Client's Name: ______________________ Record Number: ______________

Date of Birth: ______________________

I, ______________________ authorize Shelby Wellness & Therapy Center PLLC

Name of client or client's legally responsible person *Agency or person authorized to use and disclose the information*

to use or disclose to/with ______________________

Name of agency or person to whom the requested use or disclosure will be made (include address, if applicable)

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

____ Assessments
____ Psychiatric Evaluations
____ Psychological Evaluations
____ Diagnoses
____ Other: ______________________
____ Service Notes
____ Service Plans/Goals
____ Discharge Summary
____ Financial/Reimbursement
____ Substance Abuse/Treatment
____ HIV/AIDS Information
____ Social, Developmental, Medical History

PURPOSE OF USE OR DISCLOSURE ***(client must check beside data to be used or disclosed)***

____ At the request of the individual
____ Court Proceedings
____ Assessment/Evaluation
____ Determination of Benefits
____ Coordination of Service
____ Other ______________

Information requested should be mailed to this address: Shelby Wellness & Therapy Center PLLC
809 N. Lafayette Street Suite A
Shelby, NC 28150 FAX 704-448-2003

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 & 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 we disclose 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 disclosure is prohibited except as permitted or required by these two laws. I further understand that the information released may include drug and/or alcohol use, and/or HIV/AIDS diagnosis only with my specified consent. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the *Shelby Wellness & Therapy Center PLLC* Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

______________________ ______________________

Date of expiration, if less than one year ***Event, if less than one year***

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that Shelby Wellness & Therapy Center PLLC will not deny or refuse to provide treatment if I refuse to sign this Authorization.

______________________ ________ ______________________

Signature of client **Date** **Witness (required if symbol or mark is used by client's LRB**

______________________ ________

Signature of legally responsible person, if required **Date**

____

Please explain LRP authority to act on behalf of the client: **Staff Signature & Date**

☐ **Power of Attorney** ☐ **Guardian** ☐**Other** ______________________