CAROLINA
PSYCHOLOGY GROUP

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Authorization for Use and Disclosure of Protected HealthCare and Other Private Information

Name: _____ Date of Birth _____/_____/_____

I do hereby request and authorize Carolina Psychology Group to

☐ disclose to ☐ receive from
the following entities (include name, address, phone number, and fax):

_____

_____

The following protected information: ☐ Reports ☐ Results of Tests ☐ Third Party Info ☐ Medical History and Evaluations ☐ Medications ☐ Developmental and/or social history ☐ treatment plan and diagnosis ☐ Progress Notes ☐ Discharge Summary ☐ Treatment Update ☐ Acquired Immunodeficiency Syndrome, HIV ☐ Substance Use Information ☐ Drug Screen Results ☐ All of the above ☐ Other: _____

For the purpose of: ☐ planning appropriate treatment ☐ continuing appropriate treatment ☐ determining eligibility for benefits ☐ case review ☐ coordination of care with additional service providers ☐ Assessment/Evaluation ☐ Collateral Interview ☐ Referral for _____

I understand that:

- **Cancellation:** I can cancel this authorization at any time by doing so in writing, except to the extent that this authorization has already been acted upon.
- **Confidential and Sensitive Material:** I am authorizing the organization(s) listed above to share my medical or other records ***even though they may contain private information*** about sensitive subjects including: Abuse (sexual, physical, elder, spousal, etc.), abortion, genetics, mental illness, rape, sexual diseases, illness like hepatitis or AIDS, HIV and AIDS testing, and or substance abuse.
- **Copy:** I may request and receive a copy of this authorization. ☐ Request ☐ Do Not Request
- **Expiration of Authorization:** This authorization will expire on _____ or one year from the date it is signed, whichever is earlier.
- **Photocopy of Authorization:** I authorize a readable copy or fax of this authorization shall have the same force and effect as this original.
- **Redisclosure:** I understand that once information is disclosed pursuant to this signed authorization 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.
- **Voluntariness:** This authorization is truly voluntary. I understand that I may refuse to sign this authorization form and that my decision will not affect the evaluation or treatment provided me by Carolina Psychology Group.

Client Signature: _____ Date: _____

Client Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

Relationship to client: _____

Witness Signature: _____ Date: _____