OUTREACH MANAGEMENT SERVICES

Client Name:________________________________MCD/Ins.#:__________________Client#:_______________DOB:__________________

AUTHORIZATION FOR DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

I hereby request and authorize ________**OUTREACH MANAGEMENT SERVICES**________ to disclose to, receive from, and communicate with:

- ☐ NCTOPPS
- ☐ DEPARTMENT OF SOCIAL SERVICES
- ☐ DEPARTMENT OF JUVENILE JUSTICE
- ☐ SCHOOL ____
- ☐ HOSPITAL ____
- ☐ OTHER ____

The following protected information: (please initial each that applies/mark N/A if not required)Assessment

_____Psychological Evaluation
_____Treatment Plan & Diagnosis
_____Discharge Summary
_____Progress Notes
_____Financial Information
_____Substance Abuse Information
_____Psychiatric Evaluation
_____Acquired Immunodeficiency Syndrome (HIV)
_____Medical History
_____Education Information
_____Other:____

The purpose of disclosure is: ________________CONTINUED COORDINATION OF CARE____
Specific purpose for information

The date this consent expires: _365 days from date of client signature below__.

Redisclosure of protected health information is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" for substance abuse treatment and under state law G.S. 122C for mental health and developmental disabilities.

I may revoke this authorization at any time. I understand that any action taken on this authorization prior to the date I revoke it is legal and binding. I understand I may revoke this authorization by writing a letter or verbally telling the Partnership staff person I work with or by calling the Privacy Officer.

I certify that this authorization is made freely, voluntarily, and without coercion. I may refuse to sign this authorization form and OUTREACH MANAGEMENT will not condition my treatment on receiving my signature on this authorization.

____ __________________________________
Client or Personal Representative Signature Date

____ __________________________________
Parent/Guardian if client under 18 Date

____ __________________________________
Staff Signature Date

REVOCATION OF AUTHORIZATION/CONSENT

I WITHDRAW THE AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION OF ____
(Verbal Request by: _________________________) effective on: ____

____ _________________________________
Client or Personal Representative Signature Date

____ _________________________________
Parent/Guardian if client under 18 Date

____ _________________________________
Staff Signature Date