Albemarle Counseling Group
Authorization to Release and Obtain Confidential Information

This 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. 122C).

Client's name	Date of Birth	Social Security or other ID#

I authorize **Albemarle Counseling Group /** _____ to exchange information with:

_____

(*Agency or person to whom the requested use or disclosure will be made*)

The following Protected Information: _____

_____

The purpose of the disclosure is:_____

I understand that:

- With certain exceptions, I have the right to revoke this authorization at any time and I must do so in writing.
- If not revoked earlier, this authorization expires automatically one year from date of signature.
- My records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.
- When I authorize this office to disclose information to third parties, the office is unable to prevent re-disclosure by the recipient.
- The information to be released was fully explained to me and this consent is given of my own free will.
- I understand that the information to be released may include information regarding my course of behavioral healthcare treatment, diagnoses, drug abuse, alcohol abuse and health conditions including sickle cell anemia, acquired immunodeficiency syndrome (AIDS) and/or human immunodeficiency virus (HIV). (G.S. 130A-143) (*Initial to indicate understanding)* _____
- I understand that I have the right to pursue medical treatment of my choice.

Signature of Client:_____ Date:_____

Signature of Legally Responsible Person (if required):_____

Please Print Name:_____ Date:_____

_____Self _____Parent _____Guardian _____Legally Authorized Representative

Witness to Signature:_____ Date:_____

If not revoked earlier, this authorization expires automatically upon_____.

Please return the requested information to:
Albemarle Counseling Group
1129 Horseshoe Road
Elizabeth City, NC 27980
Phone: (252)- 335-2018 Fax: (252)-335-952

Note: Where substance abuse diagnosis /treatment information accompanies this disclosure form- This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Pt. 2.) The federal rules prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CFR Part 2. This authorization does not permit you to re-release any information to third parties.