AUTHORIZATION TO DISCLOSE AND EXCHANGE HEALTH INFORMATION

I (Client) _____ Date of Birth ___/___/___

Hereby authorize **LORALIE GRIGAS, MSW, LCSW, LCAS, SAE**
1328 N. Lake Park Blvd., Suite 109
Carolina Beach, NC 28428
Phone: 910-617-4675
Fax: 910-458-4824

to exchange and/or disclose specific health information from the records of the above named client with:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Specific information to be disclosed:
___ Entire Record ____ Diagnosis ___ Treatment Plan ___ Progress/TX Results ___ Testing Results
___ Recommendations ___ Number of Appointments

Other/Restrictions/Conditions: _____
_____
_____

For the purpose of:
___ Treatment coordination ___ Comply with subpoena ___ Information exchange ___ Other _____
_____

I understand that this authorization allows mutual exchange of information and will expire on the following date, event or condition *(if blank authorization will expire 1 year from date signed):* _____.

I understand that If I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose or for up to one year, whichever comes first. I may, however, specify a period longer than a year or an event which may not occur within the year .When the disclosure is for financial transactions, the authorization is valid indefinitely.

I may revoke this authorization at any time. I will be asked to sign the *Revocation Section* at the end of this form.
Any action taken on this authorization prior to the date I revoke it is legal and binding. My information may not be protected from re-disclosure by the requester of the information. However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

If my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information.
I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services. However, if a service is requested by a non-treatment provider (for example, an insurance company) for the sole purpose of creating health information (for example, an assessment), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

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REVOCATION SECTION

I do hereby request that this authorization to disclose health information of (Client) _____ signed on _____/_____/_____ be rescinded, effective _____/_____/_____ I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I hereby attest to the verbal request for revocation of this authorization by (Client or Personal Representative) _____ on (date)_____/_____/_____. The client or his personal representative has been informed that any action taken on this authorization prior to the rescinded date is legal and binding.

(Signature of Staff)	*(Date)*	*(Signature of Witness)*	*(Date)*