Paula S. Newman, PLLC
1921 North Pointe Drive, Suite 207, Box 16, Durham, NC 27705

CLIENT: **RECORD NUMBER:** **DATE OF BIRTH:** **INSURANCE#:**	**The client must always be given a copy of this form after signing.** Complete as needed. Use for disclosing information to other agencies or requesting information from other agencies. In the following cases, minors have the right to release information without parent's signature; these minors have the same rights as adults: 1. Emancipated minors 2. Minors receiving Substance Abuse treatment 3. Minors receiving treatment without parental consent.

I, [print name]____**,** hereby authorize the release of information

TO/FROM: (Please Circle) Paula S. Newman, PLLC

1921 N. Pointe Drive, Suite 207, Durham, NC 27705________________________________

Site Address **(must be specified)** Street City State Zip Code Fax

TO/FROM: (Please Circle)

1.____

Person/Agency Street City State Zip Code Phone/Fax

2.____

3.____

4.____

5.____

6.____

Person/Agency Street City State Zip Code Phone/Fax

for the purpose of assessment, treatment planning, referral, coordination of services, and/or processing or payment of claims. I have been advised that Paula S. Newman, PLLC may charge a reasonable fee for the costs of copying, mailing or other supplies associated with any request for copies.

Please **initial** below indicating which documentation regarding your treatment may be released and/or exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

Other Agency Documentation

_______Assessment/diagnoses ________Service plan(s) ________Physician's Orders/medication history
_______Treatment history ________Medical history ________Educational history
_______Social/developmental history ________Discharge summary ________Evaluation(s): __________________
_______Service note(s), dates:____________through___________ __________________
_______Other (specify) ____
_______Release of records is authorized even if such records contain information related to substance abuse.
_______Release of records is authorized even if such records contain information related to HIV/AIDS.
_______**In addition to the initial disclosure of identified information**, I authorize periodic exchange of information between Paula S. Newman and the noted agencies.

Paula S. Newman Generated Documents

_______Referral/Screening Form ________Service Plan
_______Admission Assessment ________Monthly Summaries
_______Diagnostic Assessment ________Behavior Intervention Plans
_______Transfer/Discharge Summary
_______Service Note(s) dates:__________through___________
_______Other (specify) ____
_______Release of records is authorized even if such records contain information related to substance abuse
_______Release of records is authorized even if such records contain information related to HIV/AIDS.
_______**In addition to the initial disclosure of identified information,** I authorize periodic exchange of information between Paula S. Newman, PLLC and the noted agencies.

PLEASE REFER TO PAGE 2 FOR FURTHER INFORMATION AND SIGNATURE(S)

Paula S. Newman, PLLC
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I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.

I understand what information will be released, the purpose of the release of the information, and that there are statutes and regulations protecting the confidentiality of the information. Substance abuse information is protected per the confidentiality and disclosure requirements of 42 CFR Part 2. And, HIV/AIDS information is protected under G.S. 130A-143. Paula S. Newman, PLLC's NOTICE OF PRIVACY PRACTICES describes the circumstances where disclosure is permitted or required by state or federal law without consent.

I understand the terms of this release and voluntarily give my authorization. I understand that I may refuse to sign this authorization form and understand that Paula S. Newman, PLLC will not condition my treatment, or any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this authorization. I further understand that I may revoke my authorization/consent at any time except to the extent that action has been taken in reliance on the consent, by giving written notice to Paula S. Newman, PLLC. If not revoked earlier, this authorization expires automatically one year from the date it is signed or upon ____, whichever is earlier.
(date or event specified by client or dictated by the purpose of the authorization)

Signed____ Date______________
(Specify if signature is that of client, parent(s), legal guardian, or personal representative)

Witnessed____ Date______________
(Witness signature is required only if the form is sent out of state **or** if the above client signature has been signed by a mark)

This authorization is hereby revoked upon the signed and dated request of the client as noted below:

Signed____ Date______________
(Client signature)

The client has notified me verbally that he/she wishes to revoke this authorization with an effective date of:

____

Signed____ Date ______________
(Staff signature)

THE INFORMATION RELEASED IS CONFIDENTIAL AND REDISCLOSURE IS PROHIBITED EXCEPT AS AUTHORIZED BY G.S. 122C-53 THROUGH G.S. 122C-56.