Eastern Carolina Psychiatric Services (ECPS)
2800 Village Way
New Bern, NC 28562
(P) 252-637-7300 (F) 252-637-1772

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____
SS#: _____ Medicaid ID#: _____ MR#: _____

I hereby authorize ECPS to: (Print name and address of person/agency)

_____ Release Records To _____

_____

_____ Obtain Records From _____

_____

_____ Receive and Release Information _____
(to include verbal and/or written communication)

Specific dates requested: _____ to _____

This data shall include the following information:

____ALL records
____Psychological evaluation/diagnosis
____Other_____
____Current medications
____Psychiatric evaluation

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, continuity of care and, when appropriate, coordinate treatment services. This disclosure is a request of the individual client or his/her legal representative.

Unless revoked in writing, this consent shall be valid for 365 days from the date of signing this contract, not to exceed one year.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that is deemed appropriate and consistent with applicable law, including, but not limited to verbal, written, or electronic format.

I understand in the event of an emergency/crisis per HIPAA guidelines and consistent with applicable law information can be released without consent.

I understand that disclosure may be made of pertinent confidential information without expressed consent in accordance with G.S. 122C-52 through 122C-56.

The doctrine of informed consent has been explained to me, and I understand the contents to be released and the need for the information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent in writing at any time, except to the extent that action based on this consent has been taken. I also understand that revocation of this consent will not condition my treatment.

I understand that the HIPAA privacy law protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from redisclosing it. I understand that mental health and development disability information is protected by N.C. State law (G.S. 122-C), substance abuse treatment information is protected by federal law (42 C.F.R., Part 2), and HIV/AIDS information is protected by N.C. State law (G.S. 130A-143)

Client Signature: _____ **Date:** _____

Signature of legally responsible person: _____
Printed name of legally responsible person: _____
____Parent ____Guardian ____Other _____

Witness: _____ **Date:** _____