**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

I authorize Living Well Behavioral Health, Inc. to disclose the specific health and medical information identified below for:

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***TO*:**

**Recipient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recipient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

for the following purposes: (describe each **purpose** of disclosure) **Continuity of care** and/or

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that all alcohol and/or drug treatment records and all HIV diagnosis related information are protected under the Federal Regulations governing Confidentiality of Alcohol, Drug Abuse and HIV related patient records, 42 CFR Part 2 and G.S. 130A-143 and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.

I understand that the information to be disclosed may include information regarding drug abuse, alcohol abuse, HIV infection, AIDS, AIDs related conditions, psychological, psychiatric or physical impairments.

By initialing the spaces below, I specifically authorize the use, disclosure or release of the following health information and/or medical records, if such information and/or records exist:

\_\_\_\_\_ All Clinical records \_\_\_\_\_Initial Psychiatric History & Mental Status Exam

\_\_\_\_\_Discharge Summary \_\_\_\_\_Emergency and urgent care records

\_\_\_\_\_Medication List \_\_\_\_\_Progress Notes

\_\_\_\_\_Laboratory reports \_\_\_\_\_Consultation

\_\_\_\_\_Alcohol and/or drug abuse information \_\_\_\_\_ HIV related information

\_\_\_\_\_Diagnosis(es) \_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Billing statements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be (re) disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire twelve (12) months from the date of signing or until (**applicable date or event)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Printed Client Name or Legally Responsible Person

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Client or Legally Responsible Person Date