AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION TO AND FROM ALEXANDER YOUTH NETWORK WITH ANOTHER ENTITY.

Client's Name: _____ Case Number: _____DOB: _____

I hereby request and authorize Alexander Youth Network to exchange (receive and disclose) my individually identifiable health information as specified below.

REDISCLOSURE: Once information is disclosed as authorized below, I understand that the federal health 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 redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

Entity (Agency or Person): _____

For the following purpose(s): _____

Information to be Disclosed: _____

_____

I understand that the information to be released may include information regarding Drug and Alcohol Abuse, Medical Conditions, Psychological and/or Psychiatric Impairments, and Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV). The confidentiality of alcohol and drug abuses client records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuser unless permitted by 42 CFR Part 2 §2.22. All information and records, whether publicly or privately maintained, that identify a person who has the AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to provision of this Article §130A-143shall be strictly confidential. This information shall not be released or made public except as permitted by this law. I also understand that any provider that has been previously granted access to my electronic information will continue to have access until that previous authorization expires or is revoked in writing as explained below.

As permitted by 10A NCAC 26B .0202, this consent can be revoked at any time, but will not apply to information already released. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my child's ability to receive treatment. I understand that any revocation of this authorization will need to be put in writing and will not be effective until the date it is received by Alexander Youth Network. I understand that I should provide this written statement to revoke the authorization to the assigned case manager.

As the legally responsible person, I have the right to request access to the contents of my child's records by contacting the case manager.

_____ _____

(Signature of Legally Responsible Person) *(Date)*

___Parent
___DSS Worker
___Power of Attorney
___Other_____

_____ _____

(Please Print Name) *(Relationship)*