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.

Entity (Agency or Person): _____

For the following purpose(s): _____

Information to be disclosed (include explicit description of the substance use disorder information):

_____

_____

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). I understand that my substance use disorder records, and medical health records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the 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's substance use disorder, treatment or referral for treatment 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 law, this consent can be revoked at any time, but will not apply to information already released and relied upon. I understand that this release is valid up to one year from the date I sign it, but no longer than reasonably necessary to serve the purpose for which it is provided. 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 I should provide the written statement to revoke the authorization to the assigned case manager.

REDISCLOSURE: Once information is disclosed as authorized, I understand that the federal health privacy law (45 C.F.R. 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 use disorder diagnosis, treatment or referral for 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.

_____

Client Signature Date

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.

_____

Legal Guardian Relationship Date