

**ROANOKE-CHOWAN HUMAN SERVICES CENTER  
CONSENT for RELEASE of CLIENT INFORMATION**

Client Name: \_\_\_\_\_ Client Record # \_\_\_\_\_

Client DOB: \_\_\_\_\_ Client Medicaid ID Number: \_\_\_\_\_

This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law, 45 CFR Parts 160, 164; the federal drug and alcohol confidentiality law, 42 CRR, Part 2; and state confidentiality law governing mental health, developmental disabilities, and substance abuse service, GS 122C.

I, \_\_\_\_\_, request and authorize, East Carolina Behavioral Health, 144 Community College Road, Ahoskie, North Carolina 27910, to release/receive specified information concerning me for use and/or disclosure to/from Beaufort County Sheriff's Office, 210 North Market Street, Washington, North Carolina 27889.

The data to be released/received may include the following protected information:

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> History and Physical   | <input type="checkbox"/> Lab Work/EKG                               |
| <input checked="" type="checkbox"/> Diagnoses              | <input checked="" type="checkbox"/> Discharge Summary               |
| <input checked="" type="checkbox"/> Current Medications    | <input checked="" type="checkbox"/> Service Plan/Treatment Plan     |
| <input checked="" type="checkbox"/> Screening Assessment   | <input checked="" type="checkbox"/> Progress Notes                  |
| <input checked="" type="checkbox"/> Psychiatric Evaluation | <input checked="" type="checkbox"/> Psychological/Psycho-Ed Testing |
| <input type="checkbox"/> Insurance Benefits/Claims         |   |
- Specific type: \_\_\_\_\_

- \* The following items must be initialed to be included in the use or disclosure of other health information:
- \*DWI information required for reinstatement of driving license/privileges
  - \*HIV/AIDS related health information/records
  - \*Drug/alcohol diagnoses, treatment, and/or referral information \*\*\***PLEASE INITIAL**
  - \*Urine drug screen results

Describe: (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the redisclosure of such information.)

\_\_\_\_\_

Other: Concealed Handgun Permit

**Purpose of Use and Disclosure**

The purpose of the disclosure is:

Evaluation for Concealed Handgun Permit

This consent includes information to be exchanged in verbal, written, or electronic form.

Continued on back side

Client Name: \_\_\_\_\_ Client Record #: \_\_\_\_\_

**REDISCLASURE**

Once information is disclosed pursuant to this signed authorization, 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 redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 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 laws.

**REVOICATION and EXPIRATION**

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. In any event, if not revoked earlier, this authorization expires automatically one year from the date it is signed. Revocation of this authorization must be done in writing to the Privacy Officer at 252-332-4137 or completion of the Revocation Authorization Form.

I understand that I may refuse to sign this authorization form. I understand that RCHSC will not condition the client’s treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this authorization.

**NOTICE of VOLUNTARINESS**

This consent has been explained to me and I understand its contents and the need for information to be released. I further understand there are statutes and regulations protecting the confidentiality of authorized 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 at any time except to the extent that action based on this consent has been taken.

**SIGNATURES**

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_

Signature of legally responsible person or other personal representative (if required)

\_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_

Please explain representative’s authority to act on behalf of client: (relationship)

\_\_\_\_\_

**AUTHORIZATION for USE/DISCLOSURE of CLIENT INFORMATION**