AUTHORIZATION FOR DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Client Name:

Date:

I hereby request and authorize Next Step Recovery, 900 Hendersonville Rd Ste.203, Asheville, NC 28803

to disclose to, receive from and communicate with:

_____
Individual/Organization

_____ _____ _____
Address Phone Fax

the following protected health information: (please **initial** each that applies)

___ Assessment
___ Treatment Plan & Diagnosis
___ Discharge Summary
___ Progress Notes
___ Financial Information
___ Substance Abuse Information
___ Compliance with Program
___ Other:_____

___ Psychological Evaluation
___ Psychiatric Evaluation
___ HIV / AIDS test results
___ Medical History
___ Educational History
___ Info on Perscribed Medication
___ Status with Program
___ Complete communication on case management

Redisclosure of protected health information is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" for substance abuse treatment and under state law G.S. 122C for mental health and developmental disabilities. Purpose for release is for the continuation of care.

I may revoke this authorization at any time. I understand that any action taken on this authorization prior to the date I revoke it is legal and binding. I understand I may revoke this authorization by writing a letter or verbally telling the Partnership staff person I work with or by calling the Privacy Officer.

I certify that this authorization is made freely, voluntarily, and without coercion. I may refuse to sign this authorization form and Partnership will not condition my treatment on receiving my signature on this Authorization.

_____ _____
Client or Personal Representative Signature Date

_____ _____
Staff Signature Date

Revocation of Authorization/Consent

I withdraw the authorization to disclose personal health information of_____

effective on:

_____ _____
Date Event

_____ _____
Client or Personal Representative Signature Date

_____ _____
Staff Signature Date