AUTHORIZATION FOR DISCLOSURE AND
RECIPROCAL EXCHANGE OF INFORMATION

I hereby request and authorize NSR of Asheville, 900 Hendersonville Rd., STE.203 Asheville, NC 28803

Client Name:	Date:

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
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ HIV / AIDS test results
- ☐ Medical History
- ☐ Educational History
- ☐ Info on Perscribed Medication
- ☐ Status with Program
- ☐ Other:____________________
- ☐ 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.

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