Lorven
Child and Family Development

Authorization for Use and Disclosure of Protected Health Information

This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164) the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I, _____ *(name of client or client's legally responsible person)* authorize **Lorven Child and Family Development** to use or disclose to/with

Doctor _____

Insurance Company _____

Agency _____

School_____

Person(s)_____

(Name of Doctor, Insurance Company, School, Agency, or Person to whom the requested use or disclosure will be made)

THIS DATA MAY INCLUDE ***(CLIENT MUST INITIAL FOR DATA TO BE USED OR DISCLOSED)***

☐ Assessments ☐ Service Notes ☐ Substance Abuse/Treatment
☐ Psychiatric Evaluations ☐ Service Plans/Goals ☐ Social, Developmental, Medical History
☐ Psychological Evaluations ☐ Discharge Summary
☐ Diagnoses ☐ Financial/Reimbursement

PURPOSE OF USE OR DISCLOSURE ***(CLIENT MUST INITIAL FOR DATA TO BE USED OR DISCLOSED)***

☐ At the request of the individual ☐ Assessment/Evaluation ☐ Coordination of Service
☐ Court Proceedings ☐ Determination of Benefits

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Notice of Privacy Practices, a copy of which has been given to me. If not revoked earlier, this consent shall be valid for one year from the date signed unless otherwise indicated below:

_____. _____
Date of expiration, if less than one year Event, if less than one year

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NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that *Lorven Child and Family Development,* will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____. _____

Signature of client Date Staff signature Date

_____

Signature of legally responsible person, if required Date