AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name		Date of Birth:	
Street Address		SSN (Last 4 #):	
City, State, Zip:		Telephone #:	
Email Address:			

I hereby voluntarily authorize the use and disclosure of protected health information (PHI) from my mental health record.

Facility Authorized to Release Information:	Facility or Individual(s) Authorized to Receive Information:
Wilmington Mental Health, PLLC (WMH) 3825 Market St, Ste 4 Wilmington, NC 28403 Telephone: 910-777-5575 / Fax: 910-777-5273	Name: Street Address: City/State/Zip: Telephone: / Fax:

PURPOSE OF RELEASE (check reason):

☐ Continuity of care ☐ Personal use ☐ Disability ☐ Insurance ☐ Legal Purpose ☐ School
☐ At request of Employer ☐ Other: _____

This consent will expire automatically one year from the date on which it is signed unless a date for treatment records to be released is specified next: From (date) _____/_____/_____ To (date) _____/_____/_____

Health Information that may be used / disclosed is limited to the following: [check appropriate box(es)]

☐ ____ Initials - Identifying Information ☐ ____ Initials - Clinical Assessments** ☐ ____ Initials - Attendance Records
☐ ____ Initials - Treatment Plan ☐ ____ Initials - Progress Report ☐ ____ Initials - Discharge Summary
☐ ____ Initials - Entire Record* ☐ ____ Initials – Other: _____

* Mental Health Records do not include psychotherapy notes. ** Comprehensive Clinical Assessments include background history, legal history, previous diagnostic test results, medication list, allergies, operative notes, consults, and psychiatric/behavioral diagnosis.

Sensitive Information:

☐ Substance Abuse Evaluation ☐ Drug/Alcohol Test Results ☐ Psychiatric/Behavioral Diagnoses and Assessment

PATIENT'S RIGHTS: I understand that:

- This request/authorization to release records and information has been explained to me and I fully understand it, including the nature of the records, their contents, and consequences and implications of their release. The release of information is limited to the minimum necessary to accomplish the purpose for which the request is made. This authorization is being completed freely, voluntarily and without coercion.
- I have the right to revoke this authorization at any time unless Wilmington Mental Health has acted in reliance upon it. Such revocation must be in writing and received by Wilmington Mental Health to be effective. Refusing to sign this form will not prevent my ability to get treatment, payment, or eligibility of care.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. WMH will not share or use my health information without my permission other than by ways listed in WMH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at wilmingtonmentalhealth.com. A fee may be charged for providing the protected health information.
- I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including sensitive information as indicated above.

EXPIRATION OF AUTHORIZATION - If this authorization has not been revoked, it will terminate one year from the date of my signature unless another date or event is written here: _____

X _____ ____/____/_____ **OR** ***X*** _____ ____/____/_____
Patient Signature Date Legal Representative*** Date

***** If patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form - written proof may be required.**

NOTICE - This information is to be treated in accordance with (HIPAA) privacy regulations.

This information has been disclosed to you from records the confidentiality of which may protected by federal and/or state law (45 CFR Part 164 and 164; 42 CFR Part 2). You are prohibited from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by G.S. 122C-53 through G.S. 122C-56. A general authorization for the release of other medical information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. The circumstances under which disclosure is permitted or required by state or federal confidentiality rules are described in our Notice of Privacy Practices.

☐ ID Verified ☐ Signature matches DL ☐ Electronic copy requested · Legal representative is: ☐ Guardian ☐ Parent ☐ Adult Child ☐ Spouse