Local Contact Agency
Consent for the Release of Confidential Information

I, _____ authorize,
NAME OF CLIENT

_____
NAME OR GENERAL DESIGNATION OF FACILITY MAKING DISCLOSURE

to disclose to _____ the following information:
NAME OF LOCAL CONTACT AGENCY TO WHICH DISCLOSURE IS TO BE MADE

_____
NATURE AND AMOUNT OF INFORMATION TO BE DISCLOSED, AS LIMITED AS POSSIBLE

The purpose of the disclosure authorized in this consent is to:

_____
PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law.
I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

_____ _____
Signature of Client Date

_____ _____
Signature of person signing form if not client Date

Describe authority to sign on behalf of client _____

_____ _____
Witness Date

This document was developed by the N.C. Department of Health and Human Services under grant CFDA 93.779 from the Centers for Medicare and Medicaid Services. However, the content does not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal government.

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