**RIGHTS OF PERSONS SERVED**

I was provided the handouts listed below and verbally explained my rights as a recipient of services. I understand my right to file a grievance if I am unhappy with the service provided or decisions made by others regarding the services provided. I understand it is my responsibility to notify GPSBHS of changes needed in my plan of care, schedule or issues with GPSBHS representatives**.**

|  |  |  |
| --- | --- | --- |
|  | **Title** | **Instructions** |
|  | Rights of Persons Served | For you to keep. |
|  | Rights and Privacy | For you to keep. |
|  | Grievance Documentation Form | For your use if you have a general complaint about services. |
|  | Notice of Privacy Practices | For you to keep. |
|  | PHI - Individual Requests | For your use if you have a complaint about your privacy. |
|  | Privacy Complaint Form | For you to keep. |
|  | Voter Registration Information | For your use if you are eligible to vote, but are not registered. |
|  | Discharge Policy Handout | For you to keep. |

#### 

\_\_\_\_\_\_ **Initials**

**HABILITATION PLANNING**

I have been informed of my right to, within thirty days of admission to an GPSBHS program to have an individual written treatment plan.

\_\_\_\_\_\_ **Initials**

**DISCHARGE PLANNING**

I have been informed of my right to participate in discharge planning process and have a written discharge plan at time of discharge that includes recommendations for other services.

**\_\_\_\_\_\_ Initials**

**EMERGENCY / SAFETY INTERVENTIONS**

I have been informed that GPSBHS may implement the use of an Emergency / Safety Intervention in the case of an emergency. I consent to the use of emergency / restrictive intervention when needed to ensure the individuals safety.

**\_\_\_\_\_\_ Initials**

**NON-SOLICITAION AGREEMENT**

Upon discontinuing services with GPSBHS, I Agree that I will not solicit or privately hire GPSBHS representatives for up to 90 days following discharge.

**\_\_\_\_\_\_ Initials**

**I hereby affirm that the above noted initials are mine and that I agree to the consents included. I also understand that I may withdraw any of my consent(s) at any time, either verbally or in writing.**

**Signature of Legally Responsible Person Date**

Consents must be completed annually from the date of signature above, or in the event of a change in guardianship.

**RELEASE OF INFORMATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | |  | DOB: | |  | Record #: |  |
| I, |  | | | (Individual or Legally Responsible Person) | | | |

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  | Agency (if any): | |  |
| Address: |  | | | |
| Phone #: |  | Fax #: |  | |

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Treatment |  | Referral |  | Payment |  | Other: |  |

**Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial | Information to be Disclosed | Initial | Information to be Disclosed | |
|  | Treatment Progress Summary |  | Diagnoses/Psychiatric Information | |
|  | Service Plan Documentation |  | Progress Note Documentation | |
|  | Medical History and Physical |  | Alcohol/Drug TreatmentInformation\* | |
|  | Discharge Summary |  | Verbal Communication | |
|  | HIV / AIDS\*\* |  | Other: |  |

|  |
| --- |
|  |

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.\* GPSBHS may not confirm or deny a person’s treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.**I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient’s handling of that information.** This authorization will automatically expire on: (date, not to exceed one year) or, 90 days

after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Signature of Person Served Date

Signature of Legally Responsible Person (if not self) Date

GPSBHS Representative Date

\*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.

\*\*Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.

A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered to be as valid as the origin

**RELEASE OF INFORMATION FOR PRIMARY CARE PHYSICIAN OR CCNC/CA**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | |  | DOB: | |  | Record #: |  |
| I, |  | | | (Individual or Legally Responsible Person) | | | |

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Agency (if any): |  |
| Address: |  | | |

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Treatment |  | Referral |  | Payment |  | Other: |  |

**Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial | Information to be Disclosed | Initial | Information to be Disclosed | |
|  | Treatment Progress Summary |  | Diagnoses/Psychiatric Information | |
|  | Service Plan Documentation |  | Progress Note Documentation | |
|  | Medical History and Physical |  | Alcohol/Drug TreatmentInformation\* | |
|  | Discharge Summary |  | Verbal Communication | |
|  | HIV / AIDS\*\* |  | Other: |  |

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.\* GPSBHS may not confirm or deny a person’s treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

**I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient’s handling of that information.**

This authorization will automatically expire on: (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Signature of Person Served Date

Signature of Legally Responsible Person (if not self) Date

GPSBHS Representative Date

\*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.

\*\*Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.

A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered to be as valid as the origin

**CONSENT FOR TREATMENT**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | |  |
| Service Title | |  | Program Supervisor |

I have been informed of the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability. I hereby give my consent for Great Place to Start Behavioral Health Services (GPSBHS) to provide the above named services to the above named individual. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. In addition, I understand I may refuse any services offered at any time without threat or termination of services. In addition, I have been informed that I may contact at my own expense, private physicians, private MH/DD/SA professionals or legal counsel.

**\_\_\_\_\_\_ Initials**

**FINANCIAL RELEASE OF INFORMATION**

I understand that GPSBHS may use confidential information about me to bill and be paid for services. I hereby consent for GPSBHS to release information to the funding source(s) for this purpose. I understand that it is my responsibility to notify GPSBHS within 24 hours of any information I receive regarding changes in my Medicaid or other funds that adversely affect the reimbursement of agency services.

**\_\_\_\_\_\_ Initials**

#### PERMISSION TO PROVIDE TRANSPORTATION

#### I hereby grant permission for GPSBHS contractors and representatives to provide transportation to the above named service recipient, and agree to hold GPSBHS harmless for any accident/injury that results from the provision of transportation.

**\_\_\_\_\_\_ Initials**

**PERMISSION TO SEEK EMERGENCY CARE**

I hereby give consent for my GPSBHS representative to seek and sign consent for emergency medical care if the above named person is unable to do so for themselves. It is understood that the GPSBHS representative will attempt to locate next of kin, or other legally responsible adult, as quickly as is possible in the emergency situation.

|  |  |
| --- | --- |
| Preferred Care Facility: |  |

**\_\_\_\_\_\_ Initials**

**CONTACT PREFERENCES**

I understand that one of my rights as a person served is to choose how I am contacted. I *DO/DO NOT* *(please circle one)* give permission for GPSBHS representative to contact me at work. Furthermore, I *DO/DO NOT* *(please circle one)* give permission for GPSBHS representatives to leave voice messages for me at *HOME/WORK/BOTH/NEITHER* *(please circle one).*

|  |  |  |
| --- | --- | --- |
| My preferred contact numbers are: |  |  |
|  | 1st Choice | 2nd Choice |

**Signature of Legally Responsible Person Date**

**RELEASE OF INFORMATION FOR SCHOOL**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | |  | DOB: | |  | Record #: |  |
| I, |  | | | (Individual or Legally Responsible Person) | | | |

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Agency (if any): |  |
| Address: |  | | |

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Treatment |  | Referral |  | Payment |  | Other: |  |

**Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial | Information to be Disclosed | Initial | Information to be Disclosed | |
|  | Treatment Progress Summary |  | Diagnoses/Psychiatric Information | |
|  | Service Plan Documentation |  | Progress Note Documentation | |
|  | Medical History and Physical |  | Alcohol/Drug TreatmentInformation\* | |
|  | Discharge Summary |  | Verbal Communication | |
|  | HIV / AIDS\*\* |  | Other: |  |

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.\* GPSBHS may not confirm or deny a person’s treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

**I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient’s handling of that information.**

This authorization will automatically expire on: (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Signature of Person Served Date

Signature of Legally Responsible Person (if not self) Date

GPSBHS Representative Date

\*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.

\*\*Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.

A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

**RELEASE OF INFORMATION FOR PSYCHIATRIST/NP**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | |  | DOB: | |  | Record #: |  |
| I, |  | | | (Individual or Legally Responsible Person) | | | |

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Agency (if any): |  |
| Address: |  | | |

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Treatment |  | Referral |  | Payment |  | Other: |  |

**Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial | Information to be Disclosed | Initial | Information to be Disclosed | |
|  | Treatment Progress Summary |  | Diagnoses/Psychiatric Information | |
|  | Service Plan Documentation |  | Progress Note Documentation | |
|  | Medical History and Physical |  | Alcohol/Drug TreatmentInformation\* | |
|  | Discharge Summary |  | Verbal Communication | |
|  | HIV / AIDS\*\* |  | Other: |  |

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.\* GPSBHS may not confirm or deny a person’s treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

**I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient’s handling of that information.**

This authorization will automatically expire on: (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Signature of Person Served Date

Signature of Legally Responsible Person (if not self) Date

GPSBHS Representative Date

\*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.

\*\*Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.

A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

**RELEASE OF INFORMATION FOR BEHAVIORAL AGENCY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | |  | DOB: | |  | Record #: |  |
| I, |  | | | (Individual or Legally Responsible Person) | | | |

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Agency (if any): |  |
| Address: |  | | |

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Treatment |  | Referral |  | Payment |  | Other: |  |

**Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial | Information to be Disclosed | Initial | Information to be Disclosed | |
|  | Treatment Progress Summary |  | Diagnoses/Psychiatric Information | |
|  | Service Plan Documentation |  | Progress Note Documentation | |
|  | Medical History and Physical |  | Alcohol/Drug TreatmentInformation\* | |
|  | Discharge Summary |  | Verbal Communication | |
|  | HIV / AIDS\*\* |  | Other: |  |

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.\* GPSBHS may not confirm or deny a person’s treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

**I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient’s handling of that information.**

This authorization will automatically expire on: (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Signature of Person Served Date

Signature of Legally Responsible Person (if not self) Date

GPSBHS Representative Date

\*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.

\*\*Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.

A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

**RELEASE OF INFORMATION HOSPITAL**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | |  | DOB: | |  | Record #: |  |
| I, |  | | | (Individual or Legally Responsible Person) | | | |

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Carolina East Medical Center | Agency (if any): |  |
| Address: | 2000 Neuse Blv. New Bern NC 28560 | | |

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Treatment |  | Referral |  | Payment |  | Other: |  |

**Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial | Information to be Disclosed | Initial | Information to be Disclosed | |
|  | Treatment Progress Summary |  | Diagnoses/Psychiatric Information | |
|  | Service Plan Documentation |  | Progress Note Documentation | |
|  | Medical History and Physical |  | Alcohol/Drug TreatmentInformation\* | |
|  | Discharge Summary |  | Verbal Communication | |
|  | HIV / AIDS\*\* |  | Other: |  |

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.\* GPSBHS may not confirm or deny a person’s treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

**I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient’s handling of that information.**

This authorization will automatically expire on: (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Signature of Person Served Date

Signature of Legally Responsible Person (if not self) Date

GPSBHS Representative Date

\*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.

\*\*Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.

A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

**RELEASE OF INFORMATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | |  | DOB: | |  | Record #: |  |
| I, |  | | | (Individual or Legally Responsible Person) | | | |

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Agency (if any): |  |
| Address: |  | | |

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Treatment |  | Referral |  | Payment |  | Other: |  |

**Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial | Information to be Disclosed | Initial | Information to be Disclosed | |
|  | Treatment Progress Summary |  | Diagnoses/Psychiatric Information | |
|  | Service Plan Documentation |  | Progress Note Documentation | |
|  | Medical History and Physical |  | Alcohol/Drug TreatmentInformation\* | |
|  | Discharge Summary |  | Verbal Communication | |
|  | HIV / AIDS\*\* |  | Other: |  |

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.\* GPSBHS may not confirm or deny a person’s treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

**I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient’s handling of that information.**

This authorization will automatically expire on: (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Signature of Person Served Date

Signature of Legally Responsible Person (if not self) Date

GPSBHS Representative Date

\*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.

\*\*Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.

A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered

**RELEASE OF INFORMATION FOR MCO**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | |  | DOB: | |  | Record #: |  |
| I, |  | | | (Individual or Legally Responsible Person) | | | |

hereby authorize Great Place to Start Behavioral Health Services (GPSBHS) to share the Protected Health Information (PHI) specified below with the following agency or individual:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Trillium | Agency (if any): |  |
| Address: | 201 W. First Street. Greenville NC 27858-1132 | | |

I further authorize the above named to share PHI with **Great Place to Start Behavioral Health Services**.

Protected Health Information will be disclosed for the purpose of:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Treatment |  | Referral |  | Payment |  | Other: |  |

**Only the following, initialed by the Individual/Legally Responsible Person, may be disclosed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial | Information to be Disclosed | Initial | Information to be Disclosed | |
|  | Treatment Progress Summary |  | Diagnoses/Psychiatric Information | |
|  | Service Plan Documentation |  | Progress Note Documentation | |
|  | Medical History and Physical |  | Alcohol/Drug TreatmentInformation\* | |
|  | Discharge Summary |  | Verbal Communication | |
|  | HIV / AIDS\*\* |  | Other: |  |

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this authorization at any time, verbally or in writing, except where disclosure has already occurred. I understand that the information to be disclosed may include information regarding HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. The confidentiality of alcohol and drug abuse patient information is protected by federal law.\* GPSBHS may not confirm or deny a person’s treatment to anyone outside the agency without consent in writing of the patient unless ordered by the court or disclosed for medical emergency.

**I understand that the above recipient party may not Re-release this information without my consent, and that once information is released, GPSBHS has no control over the recipient’s handling of that information.**

This authorization will automatically expire on: (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization. Refusal to sign this release will not affect my services.

Signature of Person Served Date

Signature of Legally Responsible Person (if not self) Date

GPSBHS Representative Date

\*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2.

\*\*Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S 130A-143.

A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered