



## CONSENT FOR DISCLOSURE AND EXCHANGE OF INFORMATION

Client Full Name: \_\_\_\_\_

Insurance #: \_\_\_\_\_ Client #: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize *Blue Rose Counseling, PLLC* to release and/or exchange information with:

Agency/Person: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ Address: \_\_\_\_\_

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Treatment Plan and Diagnoses  | <input type="checkbox"/> Insurance Information    | <input type="checkbox"/> School related Information/IEP |
| <input type="checkbox"/> Alcohol/Substance treatment   | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Other (Specify): _____         |
| <input type="checkbox"/> Medication/Medical History    | <input type="checkbox"/> Psychiatric Evaluation   | <input type="checkbox"/> Any information related to     |
| <input type="checkbox"/> Admission/Clinical Assessment | <input type="checkbox"/> Progress Note(s)         | assessment and treatment                                |
| <input type="checkbox"/> AIDS/HIV information          | <input type="checkbox"/> Discharge Summary        | except: _____   |

The purpose of this disclosure is for information to be shared for treatment and coordination purposes. I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it (such as child/elder abuse or neglect, suicidal or homicidal intent, or a court order signed by a judge).

Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by the law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, substance abuse/dependence, psychological or psychiatric conditions, or genetic testing this disclosure may include that information. I understand that there may be information in these records that I would not want released unless mandated to do so. Information regarding AIDS/HIV shall be protected according to G.S. 130A-143.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company or Social Services) for the purpose of creating health information (such as a mental health evaluation), service may be denied if authorization is not given.

If this consent is valid for one year (365 days) from signature date, unless revoked earlier at client's request. I further understand that I may request a copy of this signed authorization.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Barbara R. Lovelady, MSW, LCSW, LCAS

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