*Blue Rose Counseling*, PLLC

# 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: ________________________________

- ☐ Treatment Plan and Diagnoses
- ☐ Alcohol/Substance treatment
- ☐ Medication/Medical History
- ☐ Admission/Clinical Assessment
- ☐ AIDS/HIV information
- ☐ Insurance Information
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Progress Note(s)
- ☐ Discharge Summary
- ☐ School related Information/IEP
- ☐ Other (Specify): ____________
- ☐ Any information related to assessment and treatment 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