

EASTERN CAROLINA PSYCHIATRIC SERVICES (ECPS)
2800 VILLAGE WAY
TRENT WOODS, NC 28562
252.637.7300 PHONE
252.637.1772 FAX

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

(Place an X in the appropriate spaces)

(Name, Address, Phone/Fax of Doctor's Office, Person, etc.)

_____ Release Records

_____ Receive Records

_____ Receive and Release Records
(Written or Verbal communication)

For the following dates of rendered services: _____

THIS DATE SHALL INCLUDE THE FOLLOWING INFORMATION: **(Mark all that apply)**

___ ALL records (excludes "psychotherapy notes" as defined in 45 CFR 164.501)

___ Psychiatric evaluation/diagnosis

___ Psychological evaluation/diagnosis (excludes "psychotherapy notes" as defined in 45 CFR 164.501)

___ Psychotherapy Notes (at the discretion of the therapist)

___ Current medications

___ Other _____

PURPOSE: The purpose of this disclosure is to improve assessment, treatment, planning, and share information relevant to treatment, continuity of care and, when appropriate, coordinate treatment services. This disclosure is at the request of the individual client or his/her legal representative.

Unless revoked in writing, this consent shall be valid for 365 days from the date of signing this contract, not to exceed one year.

FORM OF DISCLOSURE: Unless you have specifically requested, in writing, that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that is deemed appropriate and consistent with applicable law, including, but not limited to, verbal, written, or electronic format. The doctrine of informed consent has been explained to me, and I understand the contents to be released and the need for the information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent in writing at any time, except to the extent that action based on this consent has been taken. I also understand that revocation of this consent will not condition my treatment.

I understand that the HIPAA privacy law protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from re-disclosing it. I understand that mental health and development disability information is protected by N.C. State law (G.S. 122-C), and substance abuse treatment information is protected by federal law (42 C.F.R., Part 2), and HIV/AIDS information is protected by N.C. State law (G.S. 130A-143).

SIGNATURE OF CLIENT: _____ **DATE:** _____

SIGNATURE OF LEGALLY RESPONSIBLE PERSON: _____

Printed Name of Legally Responsible Person: _____

_____ Parent _____ Guardian _____ Other _____

WITNESS: _____ **DATE:** _____

(OFFICE PERSONNEL ONLY)