CATAWBA COUNSELING ASSOCIATES, PLLC **Authorization for release of information**

P.O. Box 1654
Belmont, North Carolina 28012
Telephone: (704) 829-2005 · Facsimile: (704) 829-2006

I, _____
(patient) (former patient) (parent of patient) (guardian of patient),

hereby authorize Catawba Counseling Associates, P.O. Box 1654, Belmont, NC 28012 to:

❑ **Disclose information to** ❑ **Obtain information from** ❑ **Exchange information with**

_____
Name

_____
Address

_____
City, State, Zip

regarding _____
Patient Name DOB SS#

The information to be disclosed is:

❑ **Summary of treatment**
❑ **Other (specify)**

The purpose of this disclosure is for:

❑ **Further treatment**
❑ **Other (specify)**

I understand that my medical and psychiatric records may be protected by federal regulations which may determine the extent and nature of the information which may be disclosed pursuant to this authorization. I do hereby give this consent to the release of the records described above freely and voluntarily, and acknowledge that I am not under any force or duress. I further understand that the provision of psychiatric or medical treatment and care will not be denied by reason of refusal to sign this consent form.

I understand that the policy of Catawba Counseling Associates is to release only that information about a patient or a former patient which, in their judgment, is considered essential for the above purpose. The authorization does not obligate them to open their records for inspection, or to otherwise provide information which may violate the above policy. The information that has been disclosed to you is from records whose confidentiality is protected by federal law which prohibits you from making further disclosure of it without the specific written consent of the patient to whom it pertains.

This consent shall remain effective for the duration of treatment plus 90 days or for the purposes or periods indicated below. If no specific date, event, or condition is indicated, this consent will last no longer than reasonably necessary to serve the purpose for which it is given.

_____
(specify date, event, or condition upon which it will expire)

I understand that I may revoke (in writing) this consent at any time except to the extent that action based on this consent has already been taken.

Signed this _____ day of _____ , 20____ .

_____ _____
Signature of patient Signature of parent, guardian, or authorized representative

_____ _____
Present address Nature of relationship

_____ _____
City, State, Zip Present address

_____ _____
Witness Signature City, State, Zip

See confidentiality statement on back of this page.

over

Confidentiality of alcohol and drug abuse patient records

The confidentiality of alcohol and drug abuse patient records maintained by this office is protected by federal law and regulations. Generally, the office may not say to a person outside the office that a patient attends treatment, or disclose any information identifying a patient as an alcohol or drug abuser *Unless:*

(1) the patient consents in writing

(2) the disclosure is allowed by a court order; or

(3) the disclosure is made to medical personnel in a medical emergency or to qualified personel for research, audit, or program evaluation.

Violation of the federal law and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime commited by a patient either at the office or against any person who works at the office or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 29 odd-3 for federal laws and 42 CFR Part 2 for federal regulations.)