FREEDOM Behavioral Health Services
Patricia S. Bock, LCSW, LCAS, CCS
9933 US Business 70 Hwy West, Clayton, NC 27520
PO Box 1418, Clayton, NC 27528
Ph. 919-585-2069 Fax 919-585-2075
FreedomBHS@gmail.com

Authorization to Obtain and/or Release Information

Client Name: ____ Date of Birth: _____________________________

Previous Name: ____ SSN: ____________________________________

MID/NCHC#: ____ Service Period: ____________________________

I authorize Freedom Behavioral Health Services (FBHS) to

____ obtain and release ____ obtain only ____ release only

AND

Name ____

Address ____

Contact Ph. ____ Contact Fax ____

____ obtain and release ____ obtain only ____ release only

The minimum necessary of the following documents/information from the records pertaining to services received for the above identified client as described below. I will indicate each type of information that may be released, disclosed and/or exchanged.

__________ Outpatient, residential, or inpatient psychiatric, medical or counseling treatment including:
- ____ diagnoses,
- ____ admission information,
- ____ treatment plans, progress notes or treatment summaries
- ____ hospitalization information,
- ____ psychological testing,
- ____ lab & x-ray reports, scan results,
- ____ medications, collateral reports,
- ____ prognosis, referrals, aftercare plans, and discharge summaries

__________ Communication as needed between above individual(s)/organization(s) and FBHS staff
__________ School Records
__________ HIV/AIDS: All information relating to HIV/AIDS and/or other communicable diseases pursuant to NC GS 130A-143
__________ SA: All information relating to substance abuse pursuant to 42 CFR Part 2
__________ Legal information (not included in the above)
__________ Attendance, prognosis, and recommendations
__________ Entire record
__________ Other (please describe): ____

I understand this information will be used for:
____ services coordination/collaboration, ____ assessment purposes, ____ billing, ____ other
Explain: ____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the FBHS address. However, my revocation will not affect information obtained or exchanged prior to the fact. I understand that once the above information is disclosed, Federal Health Privacy Law 45 CFR Part 164 may not apply to the recipient and, therefore, may not prohibit the recipient from re-disclosing it.
If information has been disclosed to you from records protected by Federal confidentiality rules 42 CFR part 2 – (protection of substance abuse information) and NC GS 130A-143 (protection of HIV/AIDS information), the Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This authorization shall remain in effect for one year unless otherwise specified below.

____

X ____ __________/_______/__________
Signature of Client or Legal Representative Date

X ____ __________/_______/__________
FBHS Representative Date