CHAPEL HILL PSYCHIATRIC ASSOCIATES, PA

Chapel Hill Psychiatric Associates, PA

Authorization to Obtain and Use Protected Health Information

This authorization implements the requirements for client authorization to use and disclose health information protected by the Health Privacy Law (45 CFR, Parts 160,164) HIPAA; the federal drug and alcohol confidentiality law (42 CFR Part 2) and the NC state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 112C).

Patient Name: _____ Date of Birth: _____/_____/_____

Information to be released □ to □ from:

_____

_____

_____

Information to be released □ to □ from:
Chapel Hill Psychiatric Associates, PA
610 Jones Ferry Road, Suite 208
Carrboro, NC 27510
Tel: (919) 636-5695
Fax: (919) 442-1105

Dates of Treatment: _____/_____ to _____/_____

Purpose of Release: □ Continuity of Care □ Legal Representation □Primary Care Provider
□ Request of the Individual □ Other: _____

Information to be released:
□ History and Physical Exams □ Diagnostic test Results □ Psychological Assessments
□ Psychotherapy Notes □ Admission Information □ Discharge Summary
□ Psychiatric Evaluations □ Medication Records □ Substance Use/Treatment
□ Progress Update/ Verbal □ Treatment Plans □ AIDS/HIV Status
□ Educational Testing and Grades □ Other**:** _____
□ **All records including secondary records from outside evaluations and hospitalizations** _____ - Initialed by patient or representative

Important Rights You Should Know:

-1- This authorization shall expire 1 year from the date of signature below unless revoked prior to that date by submitting a written revocation to Chapel Hill Psychiatric Associates. If you revoke this authorization, it will not apply to information that has already been used or disclosed. The information disclosed based on this authorization may be used or re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.

-2- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services. This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure. You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

-3- If you refuse to sign this authorization, Chapel Hill Psychiatric Associates will not deny or refuse to provide you treatment. However, our inability to obtain pertinent information or to coordinate care may alter the risk benefit analysis of your treatment options and therefore which treatments are recommended.

Please document your permission or refusal by checking and initialing the appropriate section below…

I am: □ *the individual signing below*

Signature of Client_____ Date (required) _____

□ *a personal and legal representative because the patient is a minor, incapacitated, or deceased*

Signature _____ Relationship to the Client: _____
Date (required) _____

□ *Refusing consent to release information as requested.* Please Initial here: _____

Witness: _____ Date: _____