3|C CLINICAL COUNSELING &Consulting Services, PLLC
ASSESSMENT AND TREATMENT CENTER

Release of Information (ROI): Authorization for Disclosure

I hereby request and authorize Clinical Counseling and Consulting Services, PLLC to exchange (receive and disclose) my individually identifiable health information as specified below.

REDISCLOSURE: Once information is disclosed as authorized below, I understand that the federal health privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

Entity (Agency or Person):

For the following purpose(s):

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released **(Check all desired boxes)**:

Admission Assessments
Medications
Treatment Plans
Treatment Recommendations
Psychiatric Evaluations
Other:

Psychological Evaluations
Progress/Psychotherapy Notes
Discharge Summaries
Aftercare Plans/Orders

Lab Results
Alcohol/Drug Treatment
AIDS/HIV

I understand that the information to be released may include information regarding Drug and Alcohol Abuse, Medical Conditions, Psychological and/or Psychiatric Impairments, and Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV). I also understand that any provider that has been previously granted access to my electronic information will continue to have access until that previous authorization expires or is revoked in writing as explained below.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my child's ability to receive treatment. I understand that any revocation of this authorization will need to be put in writing and will not be effective until the date it is received by Clinical Counseling and Consulting Services, PLLC. I understand that I should provide this written statement to revoke the authorization to the assigned case manager.

As the legally responsible person, I have the right to request access to the contents of records pertaining myself as the patient and/or my child/adolescent as the patient, by contacting my assigned therapist at Clinical Counseling and Consulting Services, PLLC.

My signature below indicates that I have read, understand, and consent to the patient rights and responsibilities. I also acknowledge that a copy of the items listed above is available in my patient portal and can be retrieved for my reference at my leisure. I am acknowledging that I agree with the information presented within this notice.

Legal Guardian Signature: **Date:**