Beyond Academics

AUTHORIZATION TO RECEIVE HEALTH INFORMATION

Client Name: _____ **Record #**: _____ **Medicaid #:** _____ **DOB** _____

I request and authorize

_____ _____ _____

Person/agency *Address* *Phone #*

to share the specified health information in my records with **Beyond Academics, 3607 MHRA, 1111 Spring Garden St. Greensboro, NC 27412. (Fax: 336-334-3661)**

This consent to share information is (initial box): ___ reciprocal ___ to disclose only ___ to receive only

Information to be **received** from _____is indicated below by **my initials** next to each item.

___ x Admission /screening /discharge summaries

___ x Psychiatric/psychological evaluations

___ x Educational information i.e. IEP/behavior plan

___ x Diagnostic tools i.e. SNAP/IPRS

___ x Person Centered plan

___ Financial reimbursement

___ x Medication/health information

___ x Verbal exchange

___ x Guardianship information

___ x MR2

___ Other _____

Information to be **released** by Beyond Academics is indicated below by **my initials** next to each item.

___x Admission/Discharge summaries ___Progress summaries ___x Information related to goals

___x Info related to health and safety ___Financial

____ Other _____

For the purpose of ___x Service Delivery ___x Client request ___ Legal ___ x Referral

___ Benefits Maintenance ___ x Coordination of services ___x Maintaining student's health and safety

___ Other _____

Expiration Date _____(not to exceed one year) Revoked on: _____ _____

Staff Signature

_____ _____

Student Signature Date

_____ _____

Legal Representative Signature Date

_____ _____

Witness Signature Date

___ x I understand that this information is released and protected by the HIPPA Privacy Law (45 C.F.R., parts 160 and 164); the Federal Confidentiality Law (42 C.F.R., part 2); and the North Carolina Confidentiality Law (G.S., 122-C). The doctrine of informed consent has been explained to me, and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled, but not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

___ x I understand that the health information used and disclosed may include information such as alcohol abuse, drug abuse, psychological or psychiatric conditions.

___ x **REDISCLOSURE:** Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstance where disclosure is permitted or required by these laws.

___ x **NOTICE OF VOLUNTARINESS**: I understand that signing this form is completely voluntary and that I have the right to refuse signature. If I choose not to sign this form, I understand that Beyond Academics cannot deny or refuse to provide treatment, payment, enrollment in health plan, or eligibility for benefits on my refusal to sign.

___ x I authorize the release of information regarding **HIV or AIDS** related conditions ___Yes ___ No

___ x I was **offered a copy** of this release form and I received this copy on _____declined a copy ___

_____ _____
Student Date

_____ _____
Legal Representative Date

_____ _____
Beyond Academics Staff Date

REVOCATION: Sign below **ONLY** if you are revoking your Authorization

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. (If I want to revoke this authorization I must do so in writing.) The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in Beyond Academics Notice of Privacy Practices, a copy of which has been provided to me.

_____ _____
Student Signature Date

_____ _____
Legal Representative Signature Date

_____ _____ _____
Witness Date Revocation Date