Old Vineyard Behavioral Health System
3637 Old Vineyard Road, Winston-Salem, NC 27104 Phone: 336-794-4391 Fax: 336-794-4351

Authorization for Release of Confidential Information

Patient Name: _____ **DOB:** _____ **SS #:** _____

I hereby authorize reciprocal release of my protected health information with the following:

Old Vineyard Behavioral Health **3637 Old Vineyard Road** **Winston Salem, NC 27104**	**AND**	**Name:** **Address:** **Phone/Fax:**

Specific information to be disclosed:

□Dates of Service Letter □ Discharge Plan/Summary Paperwork □ Medication List □ Assessments □Labs
□Treatment Plans □ Psychiatric Evaluation & History and Physical Examination □ Physician Progress Notes
□ Entire Record □TO RELEASE INFORMATION ONLY □VERBAL COMMUNCATION OF PHI ONLY

Dates of Treatment to be disclosed: _____

For the specific purpose(s) as listed below:

□Continuity of care □ Attorney □ Insurance □ Transfer □Other (please specify)_____

- I understand that I have a right to revoke this authorization at any time. Unless otherwise revoked, this authorization will expire in 365 days.
- I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department.
- I understand that the revocation will not apply to information that has already been released in response to this authorization nor does it apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless otherwise revoked, this authorization will expire in 365 days.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

To the extent applicable, I understand that my record may contain information that is considered sensitive under the law. My signature below indicated that I permit Alcohol and/or Drug Abuse records, HIV Test/results/AIDS related information, Communicable diseases diagnoses/treatment and Mental Health treatment, if it exists, to be released according to G.S.130A-143.

This information has been disclosed to you from my records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

_____ _____
Signature of Patient or Legal Representative **Date/Time**

_____ _____
If Signed by Legal Representative, Relationship to Patient **Witness** **Date/Time**

Minor's Signature: When patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ **Date:** _____

As indicated below by my signature, I am revoking the authorization previously signed above and no further information shall be released to the above name agency and/or persons.

_____ _____ _____
Signature of Patient or Legal Representative **Date** **Time**