Recovery and Wellness Professional Services;
5 Pensacola Heights, Arden, NC 28704
Lawrence Farber, L.C.S.W.

Authorization for Disclosure of Protected Health Information

Patient: __________________________ DOB: _________________ Soc. Sec. #:_________________________

Legal Custodian: __________________________________

I authorize the disclosure of the protected health information,[i] or the information for my minor child, as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) that I authorized to receive my protected health information are not subject to federal and state health information privacy laws,[ii] subsequent disclosure by such person(s) or organizations(s) may not be protected by those laws.

I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or authorization(s) named above have taken action in reliance on this authorization.

I understand that this authorization expires in 90 days following the date of my signature for a one time release of information; and that it expires in one year following the date of my signature for the release of information for ongoing service provision.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction, and that a photocopy of this form is as valid as the original to allow release of my records.

1. I authorize the following person(s) and organization(s) to disclose my child's protected health information (as specified below)

Name(s) ____

Organization(s)/Address____

2. I authorize the following person(s) and/or organization(s) to receive my protected health information, as disclosed by the person(s) and/or organization(s) above.

Name(s) ____

Organization(s)/Address____

3. Specific descriptions of the protected health information that I authorize for disclosure.

☐ All protected health information (PHI) in my medical file. ☐ All other documents in my file.

☐ Other as specified: ____

4. Specific description of the purpose for each use or disclosure: _____________________________________

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____ ___________________________

Signed (Parent/Legal Custodian) Date

____ ______________________________

Recovery and Wellness Professional Services staff Date

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i. Protected health information (PHI) is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508

ii. These laws apply to health plans, health care providers, and health care clearinghouses