Confidential Confessions Counseling Services, PLLC

Authorization to Disclose Protected Health or Billing Request

I hereby authorize Confidential Confessions Counseling Services' to release / exchange my specified health information to the organization, agency or individual(s) shown below, in addition, I authorize the entities shown below to release information to Confessions Counseling Services.

Client Name:_____ DOB:_____

Street Address:_____

City, State, Zip_____ Phone:_____

Release Information:

FROM:	**TO:**
Name: _____	**Name:** _____
Address: _____	**Address:**_____
Fax: _____	**Fax:** _____

PURPOSE OF USE OR DISCLOSURE (client must initial beside the purpose of data to be used or disclosed)

_____At the request of the individual
_____Coordination of Service
_____Determination of Benefits
_____Assessment/Evaluation
_____Court Proceedings
_____Other

Please Send: (client must initial beside the purpose of data to be used or disclosed)

_____Assessments
_____Abuse/Treatment
_____HIV/AIDS Information
_____Social, Developmental,
_____Financial/Reimbursement
_____Service / Progress Notes
_____ Psychiatric Evaluations
_____Psychological Evaluations
_____Medical History
_____ Substance
_____ Service Plans/Goals
_____ Discharge Summary
_____Diagnoses
_____Other:_____

This authorization is valid for 180 days from the date signed or until _____ whichever is shorter. This authorization may be revoked at any time by notifying your therapist's site in writing, except when this authorization was obtained as a condition of acquiring life insurance coverage. Confidential Confessions Counseling and its affiliates cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected.

_____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient, if not Patient

ACC/Medicaid # _____ NOTICE: There may be a charge for this service

Once information is disclosed pursuant to this signed authorization, I understand that the federal 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 we disclose 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 disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws. There are additional laws regarding disclosure of HIV/AIDS information (G.S. 130A-143), this is further explained in the Notice of Privacy Practice