PEMBROKE CENTER FOR WELLNESS
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

Consumer: _____ MR NO. _____ DOB _____ SS# _____

I hereby authorize **PEMBROKE CENTER FOR WELLNESS** to disclose/obtain and/or exchange information with:

Return To:

(AGENCY/INDIVIDUAL):_____ **PEMBROKE CENTER FOR WELLNESS**

ADDRESS:_____ **773 Old Main Rd. Pembroke, NC 28372**

_____ **(O) 910-775-9201 (F) 910-521-8540**

This data shall include: **(CONSUMER INITIAL BY EACH APPROPRIATE BLOCK)**

_____ ( ) Admission Assessment
_____ ( ) Social, Family, Medical, Developmental
_____ ( ) Substance Abuse, Legal Histories
_____ ( ) Service Plan/THP/Goal Plan
_____ ( ) Needs Assessment
_____ ( ) Discharge Summary
_____ ( ) Medical Records
_____ ( ) Medication(s)
_____ ( ) Authorization(s)
_____ ( ) Admission, Discharge, Treatment Summaries from:
Specify: _____

_____ ( ) Case Management Assessment
_____ ( ) Psychological Evaluation(s)
_____ ( ) Social Work Progress Notes
_____ ( ) Psychiatric Evaluation(s)/Progress Notes
_____ ( ) Therapy Progress Notes
_____ ( ) HIV/AIDS Information
_____ ( ) Diagnoses
_____ ( ) Labs
_____ ( ) Other (specify): _____
_____

I understand this information will be used for: **(CONSUMER INITIAL BY EACH APPROPRIATE BLOCK)**

_____ ( ) Insurance/Medicaid/Medicare determination of benefits/Billing
_____ ( ) Coordination of services between agencies
_____ ( ) To assist in the development of individual service/goal plans.
_____ ( ) To assist in securing benefits from entitlement programs.
_____ ( ) Provide data to assist with evaluation/assessment/prescriptive services
_____ ( ) At the request of the consumer or legally responsible person.

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 disclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. The Notice of Privacy Practices describes the circumstances under which disclosure is permitted or required by these two laws.

I hereby acknowledge that this authorization is truly voluntary and refusal to sign will not condition my provision of treatment, payment, enrollment of health care or eligibility for benefits. I also understand that, with certain exceptions, I have the right to cancel/revoke or restrict this authorization at any time and must do so in writing. This authorization will expire automatically within 1 year from this date unless otherwise specified. The Notice of Privacy Practices describes the exceptions and the process for cancellation/revocation and restriction of this authorization.

The doctrine of informed authorization has been explained to me and I understand the contents to be disclosed, the need for the information and that there are statutes and regulations protecting the confidentiality of authorized information. **A copy of this authorization has been provided to me.**

_____ _____
Consumer Date

_____ _____
Legally Responsible Person Explain Authority Date

_____ _____
Witness Date