SouthLight

Consent to Release Information

START DATE: __/__/____ EXPIRATION DATE: __/__/____ CLIENT'S DATE OF BIRTH: __/__/____

I, _____ **hereby request and authorize SouthLight to use/**
CLIENT NAME (PRINTED)

disclose/request my protected health information to/from: _____
RECIPIENT'S NAME

RECIPIENT'S EMAIL: _____ RECIPIENT'S FAX #: _____

Information released may be verbal, electronic, or written and allows for a reciprocal exchange of information. Released information may include records, treatment notes, and other information.

Nature of records to be released:

☐ Admission Assessment	☐ Medications	☐ Treatment Plans	☐ Treatment Recommendations
☐ Psychiatric Evaluations	☐ Psychological Eval	☐ Psychotherapy Notes	☐ Discharge Summaries
☐ Aftercare Plan/Order	☐ Lab Results	☐ Alcohol/Drug Tx	☐ AIDS/HIV

☐ Other _____

I understand the purpose of the disclosure/redisclosure will be used for: ☐ Continuity of Care OR ☐ Family Support
My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGSs:§130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part .164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by by state law (G.S. 122C) or substance use treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure 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. **This consent will expire in 365 days unless otherwise stated above.**

When this authorization is requested from the consumer, a copy of this signed release form shall be provided to the consumer or legally responsible person, if requested. The consumer authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C-53(c).

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If I choose to revoke this consent, I must do so in written form.

I understand that I may refuse to sign this release of information form. I understand that SouthLight Healthcare may not condition treatment, payment, enrollment or eligibility for benefits if I refuse to sign this consent form.

☐ Verbal consent obtained

CLIENT'S SIGNATURE: _____ DATE: __/__/____

EMPLOYEE SIGNATURE: _____ DATE: __/__/____

Mailing Address: 3125 Poplarwood Court, Suite 203, Raleigh, NC 27604
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