Mountain Counseling Associates, LLC

P.O. Box 2272, Hendersonville, NC 28793 Phone: 828-692-7300 Fax: 828-692-7710

RELEASE OF INFORMATION or COORDINATION OF CARE

Client Name (Print):_____ **DOB:** _____

Medicaid /Health Choice# (if applicable) _____

I authorize _____ to ☐ release ☐ receive information to/from
Mountain Counseling Associates, LLC Provider Name

Provider/Individual/ Organization: _____
Name/Specific Organization

Address _____ **Phone** _____ **Fax** _____

Information that may be released/received:

( ) Mental Health/Physical Information: ☐ Presence and Progress in Treatment ☐ Assessments ☐ Diagnosis ☐ Demographic
Initials check all that apply ☐ TX/Recovery Plans ☐ Psychiatric Summary ☐ Medication Records

( ) Drug/Alcohol Treatment Information: ☐ Presence and Progress in Treatment ☐ Assessments ☐ Diagnoses
Initials check all that apply ☐ TX/Recovery Plans ☐ Psychiatric Summary ☐ Medication Records

( ) HIV/AIDS Information *
Initials *I understand that HIV/AIDS information will not be released without written consent. HIV/AIDS information is protected under federal regulation § 130A-143 Confidentiality of records. All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential.

☐ **Other**: _____

REASON: ☐ Provide continuity of care ☐ Compliance with program ☐ Specify _____
☐ Personal Use ☐ Legal Purposes ☐ Social Security/Disability ☐ Insurance/Managed Care ☐ Coordination of Care

Dates of Service (if left blank all dates of service) FROM _____ **TO** _____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

I have the right to:

1) Review and understand the Notice of Privacy Practices;
2) This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization;
3) Inspect and receive a copy of the material to be released;
4) Request restrictions on how my health information is used and disclosed; and
5) Receive a copy of this authorization and the Notice of Privacy Practices

This form has been fully explained and I certify that I understand its contents. I understand that the provider may not condition treatment on obtaining this consent/authorization from me. I understand this release will remain in effect for 1 year from date signed or I revoke in writing.

_____ _____
Client's Signature/Name of Individual giving Oral Consent when physically unable to sign **Date**
"I understand the nature of the release and freely give oral consent"

_____ _____
Signature of Authorized Person in lieu of Participant **Date**
☐ Power of Attorney ☐ Guardianship Order ☐ Parent of Minor

_____ _____
Witness Signature **Date** ☐ **Copy Accepted**
Oral Consent/Witness Signature **Date** ☐ **Copy Refused**