AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Client Name: _____DOB: _____Record #: _____

I, _____, hereby authorize **Eclectic Therapeutic Connections, PLLC** to share specified protected health information in my/my child's medical record with _____ located at _____. I further authorize _____ to release specified protected health information in my/my child's record to **Eclectic Therapeutic Connections, PLLC**.

The purpose of the disclosure: Assist with treatment ☐ Referral ☐ At Request of Client

☐ Other_____

This information shall include only the following:

Initial	Information	Date Released	Initial	Information	Date Released
	Treatment Progress Summary			Diagnoses/Psychiatric Information	
	Service Plan Documentation			Discharge Summary	
	Progress Note Documentation			Verbal Communication	
	Alcohol/Drug Treatment Information*			Psychological Information	
	Medical History and Physical			Other (List):	
	HIV/ AIDS Treatment Information*			Other (List):	

My right to confidentiality has been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations **federal privacy law (45 C.F.R. 164.512 of HIPAA)** protecting my confidentiality. I understand that I may revoke this consent at any time, either verbally or in writing, except where releases of information based upon this consent have already occurred. 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 treatment information protected by **federal law (42 C.F.R. Part 2)**, we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by the laws.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I understand that there may be information in these records that I would not want released unless mandated to do so. **Information regarding AIDS/HIV shall be protected according to G.S. 130A-143.** I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non—treatment provider (e.g., Insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I understand that the above recipient party, without my further consent, may not release this information, and that **Eclectic Therapeutic Connection, PLLC** is required by HIPAA privacy law to protect my health information. However once **Eclectic Therapeutic Connections, PLLC** discloses information, I understand they have no control over my privacy with regard to the recipient of the information.

This consent will automatically expire on: _____ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization.

_____ _____
Client Signature Date

_____ _____
Guardian (Relationship to Client) Date

_____ _____
Therapist Date

*Client must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2