Rae's Playze Adult Day Center
SEEING THROUGH THE EYES OF OTHERS

Authorization to Disclose Protected Health Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. This form implements the requirements for consumer authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R part 2), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S.122C). Covered entities must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorities by law. **Covered entities may use this form or any other form that complies with HIPAA, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

LAST: _____ **FIRST:** _____ **MIDDLE:** _____

OTHER NAME(S) USED: _____

DATE OF BIRTH: MONTH _____ **DAY** _____ **YEAR** _____

ADDRESS: _____

_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PHONE: (____) _____ - _____ **FAX:** (____) _____ - _____

EMAIL: _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

(please initial below)

	Primary Care Physician
	Cardinal Innovations Healthcare Solutions
	Mecklenburg County
	Department of Social Services
	Other:
	Other:
	Other:

REASON FOR DISCLOSURE
(Choose only one option below)

- □ Treatment/Continuing Medical Care
- □ Personal Use
- □ Billing or Claims
- □ Insurance
- □ Legal Purposes (Guardianship)
- □ Disability Determination
- □ School
- □ ISP Plans
- □ Other_____

WHO CAN RECEIVE THE HEALTH INFORMATION?

Person/Organization: Rae's Playze Adult Day Center Address: 7516 E. Independence Blvd.Suite 115
City: Charlotte State: NC Zip Code: 28227 Phone: (704) 563-3334 Fax: (704) 625-9456

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- □ All health information
- □ Physician's Orders
- □ Progress Notes
- □ Pathology Reports
- □ History/Physical Exam
- □ Patient Allergies
- □ Discharge Summary
- □ Billing Information
- □ Past/Present Medications
- □ Operation Reports
- □ Diagnostic Test Reports
- □ Radiology Reports & Images
- □ Lab Results
- □ Consultation Reports
- □ EKG/Cardiology Reports
- □ Other_____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Genetic Information (including Genetic Test Results)
_____ Drug, Alcohol or Substance Abuse Records
_____ HIV/AIDS Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid for one year or until the earlier of the occurrence of the death of the individual; or permission is withdrawn; or the following specific date (optional): **Month**_____**Day**_____**Year**_____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

_____

Signature of Individual or Individual's Legally Authorized Representative **Date**

_____

Printed Name of Individual or Individual's Legally Authorized Representative

If representative, specify relationship to the individual: Parent of minor_____ Guardian_____Other_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment

_____

Signature of Minor Individual **Date**