Patient #:_____

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AUTHORIZATION FOR RELEASE OF INFORMATION
(Adapted from Vaya Health Authorization for Release of Information)

(1) I, _____, AUTHORIZE THE RELEASE, SHARING AND EXCHANGE OF INFORMATION BETWEEN **ELIZABETH CONWAY WILLIAMS, PH.D.,** AND THE **INDIVIDUALS AND/OR ENTITIES LISTED AT THE BOTTOM OF THIS PAGE**.

(2) The information to be released, shared and exchanged is as follows:
__ Medical/Psychiatric Information included in a designated record set under 45 CFR § 164.524(a). This may include diagnoses, progress notes, diagnostic assessments, person-centered plans, individual support plans, treatment and medical history, medications, discharge summaries, laboratory data, Medicaid/Medicare eligibility information, and other information used to coordinate services. Records may include information from providers but this information may not be complete. Please contact your provider for complete information. You may cross out any items you do not want to be disclosed.
__ Financial Information: for example, records of payments made to providers; explanation of benefit forms
__Psychotherapy Notes _____ (Consumer initials required) □ Genetic Information _____ (Consumer initials required)
__ HIV and/or AIDS-Related Information _____ (Consumer initials required)
__Substance Use Information. _____ (Consumer initials required). This is information that may identify me as a person with a substance use diagnosis (drugs or alcohol) or someone who has received substance use treatment in the past. I understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, 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.
__ Information identified in the attached document(s). Please attach any subpoena, cover letter from your attorney or other document.
__Other
_____

NOTE: Once this authorization is completed and signed, it cannot be altered or changed in any way. If you wish to change this authorization, it must be revoked, and you must complete and sign a new authorization.

(3) The Purpose of the Release is one of the following:
__ Care Coordination, including but not limited to sharing with Community Care of NC and service providers
__ Legal Reasons (e.g., guardianship, appeals, worker's compensation, social services, concealed carry permit)
__ At my request or request of my Legal Representative
__ Other:
_____

****Please scan <u>both pages</u> (front and back) into EMR****

(4) Please release the requested information in the following manner:
__Paper documents mailed by regular U.S. mail, sent to the mailing address listed below; or
__By Facsimile to Fax Number – please include area code:
_____
__ Electronic documents sent by electronic mail, sent to the following e-mail address:
_____
__ Other
_____

(5) I understand the *recipient of these records may not protect my information from re-disclosure* ***except*** where this information includes substance use diagnosis or treatment information or falls within the definition of "psychotherapy notes" or "AIDS-related information" under HIPAA; **in those cases the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.**

(6) I understand that, if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychotherapy notes, or genetic testing, this disclosure will **NOT** include that information **UNLESS** I added my initials next to each item to be disclosed. I further understand that I am not entitled to copies of my psychotherapy notes under HIPAA.

(7) I also understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment for my services. I understand that my health information is shared between my provider and Hendersonville Pediatrics, PA, for purposes of treatment, payment and healthcare operations unless I specifically revoke authorization for those purposes. I understand that I may be discharged and/or denied services if I revoke consent to a disclosure for such purposes.

(8) I understand if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose, or for up to one year from the signature date, whichever is earlier. I also understand I may revoke this authorization at any time in writing. I further understand any action taken on this authorization prior to the date I revoke it is legal and binding.

(9) I further understand I will be given a copy of this form once this authorization has been completed.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Client or Parent/Legal Guardian Date

_____ _____
Signature of Client or Parent/Legal Guardian (**Authorization Revoked**) Date

INDIVIDUALS AND/OR ENTITIES:

Name: Name:

Address: Address:

Phone/Fax/E-Mail: Phone/Fax/E-Mail: