Authorization For Use And Disclosure Of Protected Health Information

Individual Name: _____

Entities Authorized to Receive & Disclose: Coastal Horizons Center, Inc. and Trauma Institute and Child Trauma Institute (TICTI)

Authorization: I authorize the entities identified above to communicate with one another and use, disclose, and exchange the protected information specified below for the stated purpose.

the following protected information: identifying and contact information; referral information; relevant clinical, treatment, and assessment information; the Comprehensive Clinical Assessment, when applicable; supporting documentation; and screening results and recommendations.
(Nature and extent of protected information to be disclosed, as limited as possible)

for the purpose of supporting referral screening, care coordination, and continuity of care. Coastal Horizons Center, Inc. may disclose protected health information to the Trauma Institute and Child Trauma Institute (TICTI) solely to complete an initial screening and intake and determine my eligibility for Coastal Horizons Center's TRC program. TICTI may then share its screening results and recommendations with Coastal Horizons Center to complete the referral and, when appropriate, provide TRC program services. (Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that the information to be released may include information regarding alcohol abuse, drug abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric or physical impairments.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it [refer to agency Privacy Notice], **and that in any event this consent expires automatically as follows:**

[_____] This consent shall expire one (1) year from the date executed, or
Client's Initials

[_____] _____
Client's Initials (Specification of Date, event or Condition upon which this Authorization expires)
(Not to exceed one year from date executed)

Executed this _____ day of _____ _____
Day Month Year

I understand that generally, Coastal Horizons Center, Inc. may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

_____ _____
Signature of Client Signature of Legal Guardian (when required)