

Frank Horton Associates, LLC
Workplace Consulting and Counseling

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal 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.

Client's Name _____ Date of Birth _____

Social Security # _____

I, _____, request and authorize
Name of client or client's legally responsible person

Name of Agency/person/facility/ or program authorized to use or disclose the information

to disclose to/receive from _____
Name of agency/person/facility or program to whom the requested use or disclosure will be made

the following protected information: _____
Provide a specific and meaningful description of the information to be used and disclosed

The purpose of the disclosure is _____
Describe each purpose of the requested disclosure

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This consent becomes effective on the date I sign it, and will continue in effect for 12 months from that date unless I revoke it before that time. I understand that revocation of the release must be done in writing and submitted to Frank Horton Associates, LLC.

I understand that I may refuse to sign this authorization form. I understand that Frank Horton Associates, LLC. will not condition the client's treatment on receiving my signature on this authorization. However, failure to sign this authorization may result in an incomplete assessment or discontinuity of care due to the inability to disclose/receive necessary information to/from appropriate parties.

Signature of client or legally appointed representative

Date