DELTA BEHAVIORAL HEALTH

1606 Physicians Drive, Unit 104
Wilmington, NC 28401

Authorization to Disclose Health Information

I _____ Social Security Number: _____ Date of Birth: _____
hereby authorize **Delta Behavioral Health, located at 1606 Physicians Drive, Unit 104, Wilmington, NC 28401** to communicate with and disclose to one another (Only one facility/person may be entered)
Facility/person name: _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax Number _____
the below information; and to release the above named organization and affiliated individual from all legal liabilities that may arise from this action.

Information to be released. Only specified information as indicated by my initials and checkmark by each item, including for Admission Date(s) _____ will be released.

___☐ Verify Admission/Discharge
___☐ Legal/Probation _____
___☐ Psychological Test Results
___☐ History and Physical
___☐ Medical/MD Progress Notes/orders
___☐ Insurance/Cobra/Benefits Verification
___☐ Nursing Assessment
___☐ Treatment Plans
___☐ Discharge Summaries
___☐ Medication List
___☐ HIV/AIDS Information
___☐ Insurance Payments Billed/Received
___☐ Clinical Progress Notes
___☐ Lab work
___☐ Clinical/Psychiatric/CD Assessments
___☐ FMLA/Disability Paperwork
___☐ Financial Arrangements
___☐ Crisis Plan

___☐ Other, Specify _____

for the specific purpose(s)

☐ Emergency Contact
☐ Discharge Planning/Continuing Care
☐ General/Verbal Coordination of Care
☐ Treatment Planning
☐ Insurance Verification
☐ Disability Claim
☐ Legal Purposes/Bkgrnd Invest.
☐ Continuity of Care
☐ Verify Admission/Discharge
☐ STD/FMLA Determination/coord.
☐ Family Coordination/Participation
☐ Crisis plan collaboration

☐ Other, Specify _____

I understand that my information may not be protected from re-disclosure (45 C.F.R. Part 164) by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (42 C.F.R. Part 2), the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law. 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 also 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 this authorization will expire on the following date, event or condition: _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I further understand that I may request a copy of this signed authorization.

_____ _____ _____
Signature of client Date Witness

_____ _____ _____
Signature of representative Date Relationship/Authority

STAFF USE ONLY
This release revoked on:
_____
Date

Staff Signature:

Phone: 910-343-6890 Fax 910-332-1233