Achieving Changes Counseling Services, PLLC

Outpatient Mental Health & Substance Abuse Services

3540 Clemmons Road, Suite 101, Clemmons, NC 27012
980.226.0414 (Office) 336.776.0091 (eFax)

TWO-WAY AUTHORIZATION FOR THE RELEASE & DISCLOSURE OF INFORMATION

For the purpose of Comprehensive Treatment Planning, Continuity and Coordination of Care

Client Name: ______________________________________ **DOB:** ___________________

Information Released By:

Agency/School/Individual: ____

Address: ____

City/State/Zip Code: ____

Telephone/Fax: ____

Information Released To:

Agency/School/Individual: **Achieving Changes Counseling Services, PLLC**
Address: 3540 Clemmons Rd, Suite 101
City/State/Zip Code: Clemmons, NC 27012
Telephone/Fax: 980-226-0414/336-776-0091 (Fax)

Specific Information to be Released:

__ Summary of treatment to date
__ Report
__ Discharge Summary
__ Other:____________________________________

Purpose of Disclosure:

__ Coordination of Care
__ Other:_____________________________________

Method of Disclosure:

__Written
__Verbal/Phone
__Electronic

I understand that I have the right to review the information that is being used or disclosed.

The information being released may be subject to re-disclosure. The information will continue to be protected under the Health Insurance Portability and Accountability Act (HIPAA) is re-disclosed is to another covered entity such as a health provider, health plans or healthcare clearinghouses. The information will not continue to be protected under HIPAA, but may be subject to other privacy laws or policies if the re-disclosure may be the institution is made to a non-covered entity. Achieving Changes Counseling Services, PLLC is not responsible for any disclosure made by the institution authorized to receive this information.

3540 Clemmons Road, Suite 101, Clemmons, NC 27012
980.226.0414 (Office) 336.776.0091 (eFax)

I have the right to refuse to sign this authorization form and by doing so refuse to allow the use or disclosure outlined above.

I may revoke this authorization at any time by writing Achieving Changes Counseling Services, PLLC and by completing the Authorization Revocation section of this form. However, Achieving Changes Counseling Services, PLLC may rely on this authorization until it receives written notice and signature that I am revoking it.
Treatment, payment, enrollment or benefits eligibility will not be based on obtaining this authorization.

Federal Law42 CFR Part 2 protects the confidentiality of drug and alcohol abuse patient records maintained by this facility. By my signature, I am authorizing specific information as indicated above.

_______________________________________ ___________
Client Signature (Required if 18 or Older) Date

____ ___________
Parent/Legal Guardian Signature Date

____ ___________
Therapist Signature Date

**Client or Authorized Representative was offered a copy of this signed authorization upon approval.*

TWO-WAY AUTHORIZATION FOR THE RELEASE & DISCLOSURE OF INFORMATION FORMS EXPIRE IN ONE YEAR FROM THE DATE SIGNED.