CLIENT: **RECORD #:** **MEDICAID #:** **DATE OF BIRTH:**	**The client must always be given a copy of this form after signing.** Complete as needed. Use for disclosing information to other agencies or requesting information from other agencies. In the following cases, minors have the right to release information without parent's signature; these minors have the same rights as adults: 1. Emancipated minors 2. Minors receiving Substance Abuse treatment 3. Minors receiving treatment without parental consent.

I, [print name]_____, hereby authorize the release of information

TO/FROM:
(Please Circle)

LifeSource, Inc.

_____

Site Address **(must be specified)** Street City State Zip Code Fax

TO/FROM:
(Please Circle)

1._____

Person/Agency Street City State Zip Code Phone/Fax

2._____

3._____

4._____

5._____

6._____

Person/Agency Street City State Zip Code Phone/Fax

for the purpose of assessment, treatment planning, referral, and/or coordination of services. I have been advised that **LifeSource, Inc** may charge a reasonable fee for the costs of copying, mailing or other supplies associated with any request for copies.

Please **initial** below indicating which documentation regarding your treatment may be released and/or exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

Other Agency Documentation

_____Assessment/diagnoses _____Service plan(s) _____Physician's Orders/medication history
_____Treatment history _____Medical history _____Educational history
_____Social/developmental history _____Discharge summary _____Evaluation(s): _____
_____Service note(s), dates:_____through_____ _____
_____Other (specify) _____
_____Release of records is authorized even if such records contain information related to substance abuse.
_____Release of records is authorized even if such records contain information related to HIV/AIDS.
_____In addition to the initial disclosure of identified information I authorize periodic verbal exchange of information **LifeSource, Inc.** and the noted agencies.

LifeSource, Inc. Generated Documents

_____Referral/Screening Form _____Service Plan
_____Admission Assessment _____Monthly Summaries
_____Diagnostic Assessment _____Behavior Intervention Plans
_____Transfer/Discharge Summary
_____Service Note(s) dates:_____through_____
_____Other (specify) _____
_____Release of records is authorized even if such records contain information related to substance abuse
_____Release of records is authorized even if such records contain information related to HIV/AIDS.
_____In addition to the initial disclosure of identified information I authorize periodic verbal exchange of information between **LifeSource, Inc.** and the noted agencies.

PLEASE REFER TO PAGE 2 FOR FURTHER INFORMATION AND SIGNATURE(S)

I understand the federal privacy law regarding the protection of substance abuse information per the confidentiality and disclosure requirements of 42 CFR Part 2 and the requirements for protection of HIV/AIDS information under G.S. 130A-143; however, 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 what information will be released, the purpose of the release of the information, and that there are statutes and regulations protecting the confidentiality of the information**. LifeSource's** NOTICE OF PRIVACY PRACTICES describes the circumstances where disclosure is permitted or required by state or federal laws.

I understand the terms of this release and voluntarily give my authorization. I understand that I may refuse to sign this authorization form and understand that **LifeSource, Inc.** will not condition my treatment, or any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this authorization. I further understand that I may revoke my authorization by giving written notice to **LifeSource, Inc**. Such revocation does not affect the validity of the consent for information disclosed/released prior to the revocation. If not revoked earlier, this authorization expires automatically one year from the date it is signed or upon _____, whichever is earlier.

(date or event specified by client or dictated by the purpose of the authorization)

Signed_____ Date_____

(Specify if signature is that of client, parent(s), legal guardian, or personal representative)

Witnessed_____ Date_____

(Witness signature is required only if the form is sent out of state **or** if the above client signature has been signed by a mark)

This authorization is hereby revoked upon the signed and dated request of the client as noted below:

Signed_____ Date_____

(Client signature)

The client has notified me verbally that he/she wishes to revoke this authorization with an effective date of:

_____

Signed_____ Date _____

(Staff signature)

THE INFORMATION RELEASED IS CONFIDENTIAL AND REDISCLOSURE IS PROHIBITED EXCEPT AS AUTHORIZED BY G.S. 122C-53 THROUGH G.S. 122C-56.