F I R S T

Authorization for the Use & Disclosure of Protected Information

Name: ____ Birthdate:_______________________

This form implements the requirements for individual authorization/consent to use and disclose health information protected by the Federal health privacy laws (45 G.F.R. parts 160,164), the federal drug and alcohol confidentiality law (42 G.F.R. part 2), and the state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I hereby authorize **F I R S T** and ____

☒ Disclose and/or ☒ Share and Protect Health Information.

The protected information to be used/disclosed includes: (X) all that apply, (■ or strikeout) all that does not apply. All boxes must be marked.

☒ Screening	☒ Plan of Care/ Habilitation Plan	■ Progress Notes (list dates)_______________
☒ Admission Assessment	■Substance Abuse Information ___________	____
☒ Evaluation	■HIV Information	■ Other (list below)

____

The purpose of disclosure is: ______**to support the team with education and advocacy**______________________________

Re Disclosure

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 G.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. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C), substance abuse treatment information protected by federal law (42 C.F.R. Part 2) and HIV/AIDS information under (G.S. 130A-143), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosures are permitted or required by these laws.

Consumer Files Access Statement

FIRST Staff access is on a need to know basis and the file content is only accessible with competent Individual or Legally Responsible Person's written consent. Competent adults/Guardians may have access to all confidential information in Consumer File relating to him/her that is generated by the FIRST. Consent expires one year from date signed and may be revoked at any time in writing or verbally.

Revocation and Expiration

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. (If I want to revoke this authorization, I must do so in writing.) The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the FIRST Handbook, a copy of which has been provided to me.

If not revoked earlier, this authorization expires automatically upon: ________________(Date or even that related to the Individual or the purpose of the use or disclosure) when treatment episode ends or one year from the date it is signed, whichever is earlier.

Notice of Voluntariness

I understand that I may refuse to sign this authorization form and that it is voluntary. I understand that the facility cannot condition treatment based on the signing of this authorization.

Signatures

____Date: ____________________

Signature of Individual or Legally Responsible Person

Specify Relationship to Individual and Print Name in Full: ____

Witness (optional): ____ Date: __________________

Name:	Medicaid #:	Record#