ncc

a lifetime of opportunities for people with developmental disabilities

ANNNUAL AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

RE: _____

DATE OF BIRTH:_____ SSN: _____

I authorize National Children's Center, Inc. to release/exchange the following information:

☐ Summary of Treatment (including diagnosis, services, duration and outcome)
☐ Summary of Psychiatric Treatment (including medications)
☐ Psychiatric Evaluation
☐ Psychological Evaluation/Test Results
☐ Assessment (including diagnosis, recommended services, psychosocial history)
☐ Financial
☐ Employment
☐ Other _____

☐ Initiation of and Attendance in Mental Health Services only
☐ Medical Records (including testing, diagnostic information treatment and recommendations)
☐ Academic Records (including testing, recommendations for treatment)
☐ Including, but not limited to, information disclosed to this agency from others
☐ Individual Treatment Plan/ Service Reviews
☐ Progress Notes

TO: Name of Person/Agency: _____

Address: _____

City:_____ State:_____ Zip Code: _____

FOR THE PURPOSE OF: ☐ Continuity of care and treatment planning
☐ Third party reimbursement
☐ Other: _____

This consent is valid until _____/_____/_____

I understand that this information may be transmitted in written, verbal and/or electric form. I understand that I may revoke this consent at any time and that the above named person authorized to receive this information has the right to inspect and copy the information to be disclosed. I understand that the requested records may contain information regarding psychiatric treatment, drug/alcohol abuse treatment, and/or HIV testing.
I understand that I (or a guardian as provided by statute) have the right to inspect and copy information to be disclosed.

It has been explained to me that if I refuse to consent to this release of information, the following are consequences, if any: _____

Client Signature: _____ Date: _____/_____/_____

Guardian Signature: _____ Date: _____/_____/_____

Witness Signature: _____ Date: _____/_____/_____
(Name/Staff Position)

Copy given/mailed to client/guardian on: _____ _____
Date Staff Signature

NOTICE TO RECEIVING AGENCY/PERSON: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to this re-release.

Under the Federal Regulations (CFR) Title 42, Confidentiality of Alcohol and Drug Abuse Records, July 1975, no such records, nor information from such records may be further disclosed without specific authorization for such re-disclosure.