Consent for Release of Confidential Information

Angela Wiley MA, LPC, LPCS, CCS, LCAS, NCC, MAC, BC-DMT, RDT/BCT, CTS
Greensboro Dance & Drama Therapy
5603 B West Friendly Ave #103 Greensboro, NC 27410
Phone: (336) 698-6723

I _____ authorize Angela Wiley to disclose to _____
(Name)

_____ _____
(Address of person or agency) (Phone Number)

Information regarding: _____ Date of Birth:_____

I also authorize the above person/agency to release information to Angela Wiley
X yes □ no Signature _____

Following information: (Check as many as apply)

□ Attendance □ Progress in program □ Progress notes
□ Intake forms □ Alcohol and other drug history □ Entire record
□ Family involvement in treatment □ Other: _____

The purpose of the disclosure authorized in this consent is (check all that apply)

□ Continuity of care □ Fee collection □ Legal representation
□ Comply with court mandate □ Other: _____
(Purpose of disclosure as specific as possible)

I understand that my mental health treatment is protected under HIPAA regulations and that alcohol and/or drug treatment records are protected by the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Record, 42 C.F.R. Part 2. This information cannot be disclosed without my written consent unless otherwise provided for in the regulations. However, HIPAA requires this program to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by the HIPAA rules. All information regarding HIV/AIDS is protected under G.S. 130A-143 and all information and records that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential. Except if the exceptions in 130A-143 apply.

I understand that this authorization is voluntary and is not a condition to receive treatment. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal or state privacy regulations.

I understand I may revoke this consent at any time except that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____1 year_____
(Specification of the date, event, or condition upon which this consent expires)

_____ _____
Client's Signature Date/Time

_____ _____
Witness Signature Date/Time