Consent for Release of Confidential Information DSS

Angela Wiley MA, LPC, LPCS, LCAS, CCS, 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 _____ (acting DSS guardian) authorize Angela Wiley to disclose information to:
(Initial)
____ Any and all Guilford County DSS workers directly involved in the child or family's case.
____ Any and all GAL involved in the case.
____ Any and all therapeutic foster parents or regular foster parents directly involved in the case.
____ Any biological, step parents or adoptive parents directly involved in the case.
____ And _PCP to get service order/cont of care (name of PCP)_____
(Name) (Address of person or agency) (Phone Number)
Information regarding_____ _____ **Date of Birth:**___ _____

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

The following information to be released: (Check as many as apply)
□ Attendance
□ Intake forms
□ Family involvement in treatment
□ Discharge summary
□ Progress in program
□ Alcohol and other drug history
□ Progress notes
□ Relapse Prevention Program
X Entire record □ Other: _____
The purpose of the disclosure authorized in this consent is (check all that apply)
X Continuity of care
□ Legal representation
□ Fee collection
□ 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 redisclosed 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 when the child and/or family listed above has a closed case with Guilford County DSS.

_____ _____
Acting DSS Guardian's Signature Date/Time

_____ _____
Witness Signature Date/Time