GRANDIS
Evaluation Center
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Authorization for Use & Disclosure of Protected Information

Client Name_____ DOB/SSN_____
Medicaid #_____
I understand that I may refuse to sign this form and that services cannot be denied based on my refusal to sign. This form implements the requirements for client consent to use and disclose information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), HIV-AIDS (45 C.F.R. Parts 160 & 164) and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I hereby authorize:_____

To ☐ Disclose and/or ☐ Share Protected Health Information with:
Grandis Evaluation Center PC

The purpose of this disclosure is for: **Assessment** ☐ **Outpatient therapy** ☐

The protected information to be used/disclosed includes: √ all that apply

☐ Evaluation (s) ☐ Substance Abuse Information ☐ HIV Information ☐ Progress Notes

☐ Other: (List): exchange of information

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REDISCLOSURE (See Notice of Privacy Act)
Once information is disclosed I understand that laws protecting health information may not apply to the recipient. When the Grandis Evaluation Center, PC discloses information regarding mental health, developmental disabilities and or substance abuse treatment we must inform the recipient that redisclosure is prohibited except as permitted and/or required by law.

REVOCATION/EXPIRATION
I understand that, with certain exemptions, as described in the Notice of Privacy Act, I have the right to revoke this authorization (in writing) at any time. If not revoked in writing this authorization automatically expires one year from the below signed date or _____.

_____ _____
Signature of Client or Legally Responsible Person Date

(Relationship to client)_____
Witness_____
Date _____