OLIVER'S
CONTRACTING, CONSULTING, & COUNSELING SERVICES

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

Number: _____ Date of Birth: _____

I, _____, here by request and authorize

_____ to release/receive specified information

Name of agency/person/facility authorized to use or disclose the information

concerning me for the and/or disclose to/from Oliver's Contracting, Consulting, & Counseling Services, PLLC, and it contracted therapists, 4108 Park Rd. Ste 408 Charlotte, NC 28209-2262 office 704-777-4525, fax 980-498-7005.

Name of agency/person/facility to whom the requested use or disclosure will be made

This data shall include:

__ Screening Assessment __ Current Medications __Insurance Benefits/Claims __ Correspondence __Identification/Face Sheet __ DWU Information __Admission Assessment __HIV/AIDS related information, __ Services Order __Drug/Alcohol Screen Results __Psychological Testing/Psycho-Ed Testing __ Level Of Eligibility __Service Plan/Treatment/Habilitation Plan __Discharge Summary __ Medication Information __ Services Notes (Specify Dates) _____to _____ Other: _____

The purpose for releasing this data shall be _____ (Purpose or need for disclosure)

I understand the information to be released may include information regarding drug abuse, alcohol abuse, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), test for infection with Human immunodeficiency virus (HIV), or psychological or psychiatric impairments.

I understand that I may refuse to sign this authorization form. I further understand that Oliver's Contracting, Consulting & Counseling Services, PLLC will not share condition my treatment on receiving my signature on this authorization form. I certify that this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under state and federal law.

REDISCLOSURE

Once information is released pursuant to this signed authorization, I understand that the federal privacy law (45 C.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 I disclose mental health and developmental disabilities information protected by stated law (G.S.122C) or substance abuse treatment information protected by federal law (42 C.F.R Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. Oliver's Contracting, Consulting, & Counseling Services, PLLC's Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

EXPIRATION

If not revoked sooner, this authorization automatically expires upon _____, or one (1) year from the date it is signed, whichever is earlier.

SIGNATURES

Signature of client:_____ Date: _____

Signature of witness:_____ Date: _____

Signature of legally responsible person/rep. (if required: _____ Date: _____

Revocation of Consent

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it or pursuant to Oliver's Contracting, Consulting, & Counseling Services, PLLC "Notice of Privacy Practices". For revocation only, you must either sign below or send a letter indicating your intent/wish to revoke as specified in OCCCS "Notice of Privacy Practices."

I, _____, hereby wish to revoke this authorization effective _____ due to the following reason(s):_____.

Signature of client: _____ Date: _____

Signature of witness: _____ Date: _____