Authorization for Release of Information

Client Name: _____ **Date of Birth:** _____

I, the below signed, hereby authorize Milestones Mental Health and Wellness (which includes all

providers in the practice) to release information to _____

_____,
and in turn I authorize the named persons/agency above to release information to Milestones Mental Health and Wellness. I understand that the purpose of this information is for consistency in care and treatment and shall include only that of the nature and to the extent specified below. Please initial beside each category authorized.

_____ Copies of medical and/or psychiatric treatment history

_____ Family/Social History

_____ Medical History

_____ Current and Previous medications

_____ Legal history

_____ Substance use/abuse documentation

_____ Documentation regarding HIV, AIDS, sexually transmitted diseases

_____ Other - Specify: _____

I understand the contents to be released, the need for the information, and that there are state and federal regulations protecting the confidentiality of authorized information. I also understand that this information cannot be released without by written consent and hereby acknowledge that this consent is truly voluntary and is valid for one year or upon the following specified date _____ (not to exceed one year from date of signature). I acknowledge that services are not contingent upon this release, or revocation of this release. I further acknowledge that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on the authorization. I understand that law prohibits re-disclosure of any information disclosed to the recipient pursuant this authorization by a plan or provider covered by HIPPAA privacy regulations unless this authorization specifically authorizes such disclosure. Information related to drug and alcohol use in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2. All information and records, which 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 G.S. 130A-143 shall be strictly confidential. This information shall not be released or made public except under circumstances outlined in G.S. 130A-143.

_____ _____

Client or Legal Guardian (if under age 18) Signature Date

_____ _____

Witness/Title Date