Open Hearts Art Center
Consent for Release of Information

Name: ____________________________ Record: _____________________

DOB: ________________ Med ID#: __________________________ Client SS#_____________
(*optional)*

I hereby authorize the following person/facility to release specified written and/or verbal information in my client record to **Open Hearts Art Center**:

Name: ____

Address: ____

OR
I hereby authorize mutual exchange of written or verbal information between **Open Hearts Art Center** and the following person/agency:

Name: Vaya Health including assigned Care Coordinator (_________________________)
Please identify Care Coordinator's name and phone number

Address: __200 Ridgefield Court; Asheville NC_____________ _________________________

I understand that this authorization will expire on the following date, event or condition:

____

INFORMATION to be released/received:

	Released	Received
Evaluations		
Treatment Plan	x	x
Discharge Summary	x	x
Clinical Notes	x	x
Service Authorization	x	x
Medication Information	X	X
Admission Assessment		
Screening Forms		
Psychiatric Forms		
Psychological Assessments		
School Records		
Other- complete ISP and/or CP and pertinent behavioral health records to determine admission into OHAC		X

PURPOSE:

	Check all the apply
Coordination of Care	X
Monitoring /Auditing	
Items related to Quality Assurance Reviews	
Billing	
Other	

Name: ______________________________ Record: ____________________

DOB: __________________ Med ID#: ______________________________ Client SS#______________
(*optional*)

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign a revocation form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will not include that information.

> * Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S. 130A-143. Whenever authorization is required for the release of this information, the consent shall specify that the information to be released includes information relative to HIV infection, AIDS or AIDS related conditions. Alcohol and drug abuse client records are protected under the federal regulations, 42 CFR Part 2 and **cannot** be disclosed or **re-disclosed** without the patient's **written** consent unless otherwise provided for in the regulations

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

______________________________ __________ ______________________________

Client Signature Date Witness if Required

______________________________ __________

Legally Appointment Representative Date