Cape Fear Developmental Therapies PLLC

KAREN S. KIRK, PhD / AITZA GALARZA, PhD ***ASHLY CARPER, LCMHC***
Licensed Child / Adolescent Psychologists ***Licensed Clinical Mental Health Counselor***

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AUTHORIZATION FOR USE / RELEASE of PROTECTED HEALTH INFORMATION

I, _____, authorize Cape Fear Developmental Therapies (Dr. Karen Kirk or Dr. Aitza Galarza, Licensed Psychologists or Ashly Carper, Licensed Clinical Mental Health Counselor) to

Release_____ *(Please initial)* **Mutually Exchange**_____ *(Please initial)*

individually identifiable confidential mental health information as described below.

Name /Agency: _____

Phone/Fax: _____ *Covering the period:*_____

For my child or adolescent: _____ *Date of Birth:* _____

Information to be shared for purposes of: _____

Content of information to be shared:
_____Psychological information: evaluation summary, treatment plans, formal testing and assessment records
_____Educational records – academic and behavioral, to include completion of rating scales
_____Medical and medication information – to include psychiatric treatment
_____Family and social information
_____Substance use or abuse information
_____Legal information
_____HIV / AIDS information

I understand that the shared information is intended to be used for specific purposes related to psychological / counseling services for my child / adolescent at Cape Fear Developmental Therapies. Those purposes can include determination of insurance benefits, support for the development of appropriate treatment goals, coordination of services between service providers, and/or advocacy on behalf of my child / adolescent. I understand that Dr. Kirk, Dr. Galarza, nor Ms. Carper will condition my child's / adolescent's psychological treatment on my refusal to sign this authorization.

I may revoke this request at any time except to the extent that action based on this request has been taken. This request will automatically expire 6 months after the day it is signed. I release Dr. Kirk, Dr. Galarza, Ms. Carper, and their staff from any liability connected with the use of these records, or the information in them, by anyone outside of the Cape Fear Developmental Therapies office. I understand that I have the right to seek assurances from the persons/organizations authorized to receive the information that they will not redisclose this information to any other party without my further authorization. Signing this form indicates authorization for this information to be exchanged or released by phone, the US Postal Service, fax, e-mail, or other courier service.

This authorization is fully understood and is made voluntarily on my part, on behalf of my child / adolescent.

_____ _____ _____
Signature of Responsible Party Relationship to Client Date

This authorization form implements the requirements for individual authorization to use and disclose health 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), the state HIV/AIDS confidentiality law (NC G.S .130A-143), and the state confidentiality law governing mental health, developmental disabilities, and substance abuse services (NC G.S. 122C).