Catholic Charities of the Diocese of Raleigh, Inc.

Authorization for Use and Disclosure of Protected Information

Client's Name	Social Security #	Date of Birth

I, _____, request and authorize
Name of client or guardian (print)

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

_____
Address of named agency/person/organization above

to use or disclose to _____
Name of agency/person/organization to whom the requested disclosure will be made

_____
Address of agency/person/organization requesting information

the following protected information: _____

_____

_____

_____

_____

The purpose of the disclosure is: _____

_____

_____

_____

The following items must be initialed in order to be included in this request for use or disclosure:

____ HIV/AIDS related information
____ Drug and alcohol treatment information

This request and authorization to release information is based on my understanding of the content of my records and the use of the information once it is released. I understand that if the person or organization receiving this information is not a health care provider, health care

organization, or health plan covered by federal privacy regulations, then this information may be disclosed and no longer be protected by these regulations. I release the source of the information from all liability arising from the release of the protected information. I understand that the willingness of the party requesting the information to treat me will not be affected by the response of the source for the requested information.

I understand that this authorization is subject to revocation at any time, provided I do so in writing, except to the extent that action has been taken upon this authorization.

Please submit any requests to revoke a previously signed authorization to your therapist, the Regional Director, or Clinical Supervisor.

I give permission to disclose the above information by use of the following method:
(Please initial)

[ ] Regular mail
[ ] Telephone
[ ] Email
[ ] Fax

I understand that this consent will automatically expire (not to exceed one year):

[ ] upon satisfaction of the need for disclosure; or

[ ] within _____ days from the date signed; or

[ ] under the following condition(s):

_____

_____

_____ _____
Signature of Client *Signature of Legally Responsible Person*

_____ _____
Signature of Witness *Date*

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Section below is to be completed by Catholic Charities staff or certified volunteer.

[ ] Information sent as requested on _____ by the following method:
Date

[ ] Regular mail
[ ] Telephone
[ ] Email
[ ] Secure Fax (transmission by this method does not need to be verified)
[ ] Unsecured Fax

Verification that information was received by fax or email:

_____
Name of person verifying information was received

_____
Client Initials