1175 Revolution Mill Drive, Suite 29-2
Greensboro, NC 27405
(336) 457-0827

Consent for Dual Release of Information

_____ _____ _____

Client's Name Date of Birth Record/ID #

I hereby authorize: _____

Name of Person Releasing Information (e.g., PCP, psychiatrist, school staff)

to release specified information in the treatment record of the above-named client to Amanda Kirby Counseling, P.C. and, in addition, authorize Amanda Kirby Counseling, P.C. to release specified information in this client's treatment record to:

_____

Name of Person Receiving Information (e.g., PCP, psychiatrist, school staff)

_____

Address City State Zip Phone/Fax Number

The purpose for release of this information is: _____

SPECIFIC INFORMATION TO BE RELEASED:

___ Psychosocial Assessment, which may include reason(s) for referral; diagnosis; prognosis; treatment plan/goals; psychotropic medications prescribed past and present; psychiatric, psychological, social, and medical information affecting current functioning.

___ Alcohol/drug-related information, which may include assessment, diagnosis, medication, and treatment. (To be released in accordance with 42 CFR Part 2)

___ HIV/AIDS information, which may include diagnosis, medication, and treatment. (To be released in accordance with NC General Statute 130A-143)

___ Discharge Summary, which may include reason(s) for referral; treatment and response; reason for discharge; issues needing continued clinical attention; and aftercare recommendations.

___ School Report, which may include academic achievement, behavior, and attendance information.

___ Other information: _____

I understand this information will be used ONLY TO FACILITATE AND COORDINATE DELIVERY OF SERVICES IN THE BEST INTEREST OF THIS CLIENT. It may be communicated through written, oral, photocopy, or electronic means.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid for a period not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that the action based on this consent has been taken. In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

_____ _____

Client/Legal Guardian Date

_____ _____

Witness Date