TRINITY
WELLNESS CENTER

1907 South 17th Street Suite 1 Wilmington NC 28401 | PH: 910-343-8424 | FAX: 910-343-6989

Authorization for Use and Disclosure of Protected Health Information

I, _____ authorize Trinity Wellness Center and _____
to communicate with and disclose to one another the following information:

__ Medical and Substance Abuse histories/notes
__ Laboratory and X-Ray results & physical examination findings
__ Treatment participation | Progress, status in the program, and treatment recommendations
__ Medication and medical orders
__ Substance Abuse | Medical & Psychiatric Diagnosis and/or impressions
__ Individual identifying health information (i.e., date of birth)
__ **All Records**

for the purpose of coordinating substance abuse, medical and/or psychiatric care.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR Parts 160 and 164 and state confidentiality law governing substance abuse services (G.S. 122 C) cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that the information to be released may include information regarding alcohol abuse, drug abuse, HIV infection, AIDS, and AIDS related conditions, psychological, psychiatric, or physical impairments.

I also understand that I may revoke this consent in writing at anytime except to the extent that action has been taken in reliance on it [refer to agency Privacy Notice], and that in any event this consent expires automatically as follows:

_____ **This consent shall expire in one (1) year from the date executed.**

Or at the date provided: __/__/___

I understand that generally, Trinity Wellness Center, may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstance I may be denied treatment if I do not sign and authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

Signature of Client: _____ Date: ____/____/_____

Date of Birth: ____/____/_____