CONSUMER NAME: ____	RECORD #:_______________

CONSENT FOR RELEASE OF INFORMATION

SOCIAL SECURITY #___________________________ DATE OF BIRTH: ____

I hereby authorize _______________________________to release specified information regarding my treatment to ALEXANDRIA L. WESTFALL, MA, LPA. I hereby authorize ALEXANDRIA L. WESTFALL, MA, LPA to release specified information regarding my treatment to _____________________________________.

This data shall include only that of the nature and to the extent specified below:

( ) Reason for Referral
( ) Psychiatric Use
( ) Psychological
( ) Social
( ) Medical Information
( ) HIV or AIDS Related Information
( ) Alcohol/Drug Treatment history
( ) Complete Administrative Record for Monitoring and Review
( ) History of Psychotropic Medications
( ) School Academic Achievement and Behavior
( ) Current Medications
( ) Other Information
____
____
____
____

I understand this information will be used for :

( ) Treatment planning
( ) Continuity of care
( ) Assessment
( ) Authorization of services
( ) Crisis Planning

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws. I certify that this authorization is made freely, voluntarily, and without coercion. I understand that I may revoke this consent at any time, except to the extent that action has already been taken. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure and is valid for only one year from the date signed. I also certify that I was given a copy of ALEXANDRIA L. WESTFALL, MA, LPA's Privacy Statement.

____________________________ ________________
Client Date

____________________________ ________________
Parent/Legal Guardian Date

____________________________ ________________
Alexandria L. Westfall, MA, LPA Date

CLIENT NAME: ____	RECORD #:_______________