New Directions Treatment Center for Anxiety and Depression
2990 Bethesda Place Suite 602B; Winston Salem, NC 27103
Telephone: (336) 768-8281 Fax: (336) 768-5685

Authorization for Use or Disclosure of Protected Health Information

Name of Patient _____
Date of Birth _____ SS# _____ Medical Record # _____
Daytime Phone _____ Evening Phone _____
Address _____
City _____ State _____ Zip Code _____

I hereby authorize **New Directions Treatment Center** to use or disclose my protected health information as indicated below to and from:

Name _____
Daytime Phone _____ Fax _____
Address _____
City _____ State _____ Zip Code _____

Information to be released:
From & To Dates_____
- ☐ Lab report _____
- ☐ X-ray report _____
- ☐ Consultation report _____
- ☐ Other _____

Purpose of Disclosure:
- ☐ Changing physicians
- ☐ Continuing Care
- ☐ At my (patient) request
- ☐ Workers' Compensation
- ☐ Second Opinion
- ☐ Legal
- ☐ Insurance
- ☐ School
- ☐ Other_____

I understand that this health information may include HIV-related information and/or relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- ☐ Substance Abuse (including alcohol and drugs)
- ☐ Mental Health
- ☐ Psychotherapy Notes
- ☐ HIV related information (including AIDS related testing)

The confidentiality of this record is required under North Carolina Statue 143-518, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statues.

X_____ _____
Signature of Patient or Legal Guardian Date

1. I understand that this authorization will expire one year from the date of my signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the New Directions Treatment Center Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as alcohol/substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I will get a copy of this form after I sign it, at my request.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian Date

_____
Relationship to Patient

_____ _____
Witnessed By Date

Date Request Filled _____ By _____
Mailed _____ Picked up _____ ID Presented _____ Name_____