



**NEXT STEP RECOVERY HOUSE FOR WOMEN**  
**Authorization for Disclosure and Reciprocal Exchange of Information**

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

I hereby request and authorize **Next Step Recovery, Inc. at 56 N. Main St., Weaverville, NC 28787**

to disclose to, receive from and communicate with:

\_\_\_\_\_ Individual/Organization

\_\_\_\_\_ Address

\_\_\_\_\_ Phone

\_\_\_\_\_ Fax

the following protected health information: (please **initial** each that applies)

- \_\_\_\_\_ Assessment
- \_\_\_\_\_ Treatment Plan & Diagnosis
- \_\_\_\_\_ Discharge Summary
- \_\_\_\_\_ Progress Notes
- \_\_\_\_\_ Financial Information
- \_\_\_\_\_ Substance Abuse Information
- \_\_\_\_\_ Compliance with Program
- \_\_\_\_\_ Other: \_\_\_\_\_

- \_\_\_\_\_ Psychological Evaluation
- \_\_\_\_\_ Psychiatric Evaluation
- \_\_\_\_\_ HIV / AIDS test results
- \_\_\_\_\_ Medical History
- \_\_\_\_\_ Educational History
- \_\_\_\_\_ Info on Prescribed Medication
- \_\_\_\_\_ Status with Program
- \_\_\_\_\_ Complete communication on case management

*Redisclosure of protected health information is not allowed under Federal confidentiality rules of 42 C.F.R. Part 2 and the "Privacy Standards" for substance abuse treatment and under state law G.S. 122C for mental health and developmental disabilities.*

I may revoke this authorization at any time. I understand that any action taken on this authorization prior to the date I revoke it is legal and binding. I understand I may revoke this authorization by writing a letter or verbally telling the Partnership staff person I work with or by calling the Privacy Officer.

I certify that his authorization is made freely, voluntarily, and without coercion. I may refuse to sign this authorization form and PARTNERSHIP will not condition my treatment on receiving my signature on this Authorization.

\_\_\_\_\_ Client or Personal Representative Signature

\_\_\_\_\_ Date

\_\_\_\_\_ Staff Signature

\_\_\_\_\_ Date

Revocation of Authorization/Consent	
I withdraw the authorization to disclose personal health information of _____	
effective on: _____	_____
Date	Event
_____ Client or Personal Representative Signature	_____ Date
_____ Staff Signature	_____ Date