COASTAL HORIZONS CENTER, INC.

"Promoting choices for healthier lives and safer communities"

Authorization For Use And Disclosure Of Protected Health Information

This form is to be completed by the school administrator and faxed to John Dail @ (910) 202-0843. Please print clearly.

I, _____, **authorize** Coastal Horizons Center Inc., parent/
Students's name
guardian and the New Hanover County School System **to communicate with and disclose and re-disclose to one another the following information:** appointment dates, attendance, personal identification, interview findings/reports which may include but are not limited to substance abuse, health, psychological, family, educational, employment, interpersonal information, recommendations, referrals for additional services **for the purpose of** coordinating substance abuse prevention and/or treatment services. This information may also be redisclosed to _____. _____
(Initial and date)

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 ("HIPAA"), 45 CFR Parts 160 & 164 and state confidentiality law governing substance abuse services (G.S. 122C) 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 or AIDS related conditions, and psychiatric, psychological or physical impairments. I also understand that I may revoke this consent in writing at any time 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 expires:

_____
(Date (mm/dd/yyyy), event or Condition upon which this Authorization expires (Not to exceed one year from date executed)

Executed this _____ day of _____ _____
Day Month Year

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

_____ _____
Signature of Student (Not valid unless signed)

Signature of Legal Guardian