SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

New Consumer Intake Demographic Form

(Please complete all fields in **BLACK INK ONLY**)

Date of Intake:_____ Time of Intake:_____

Client Full Legal Name:_____

Maiden Name (if applicable):_____ Preferred Name: _____

Client Social Security #:_____ Date of Birth: _____

Physical Address: _____

City: _____ State: _____ Zip Code:_____

Main Contact #: _____ Alternate #: _____

Email address: _____

Mailing Address (if different than above):

Client Gender: ◯Male ◯Female ◯Other Pregnant: ◯Yes ◯No ◯N/A

Proficient in English: ◯Yes ◯No Secondary Language?: ◯Yes:_____

Marital Status: ◯Single ◯Married ◯Separated ◯Divorced ◯Widowed ◯Committed

Race: ◯Black ◯White ◯Hispanic ◯Native American ◯Asian ◯Multiracial
◯Other:_____

Does the client have a Legal Guardian and/or is the client a minor child? ◯Yes ◯No

Legal Guardian Name:_____

Relationship to client: _____ Phone #: _____

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

New Consumer Intake Demographic Form Cont'd

(Please complete all fields)

Highest Level of Education Completed: _____

Employment Status:

◯Employed full time ◯Employed part time ◯Student ◯Homemaker ◯Unemployed

◯Retired ◯Unable to work/Disabled ◯Active Duty Military ◯Veteran ◯Other Military

Living Arrangements:

◯Private Residence ◯Other independent housing ◯Homeless (shelter, car, etc.)

◯Group Home ◯Foster Home ◯Assisted Living ◯Other: _____

Accommodations for Handicapped needed: ◯Not Applicable

◯Physical Disability ◯Wheelchair/Mobility concerns ◯ Sign Language ◯Visually Impaired

◯ Intellectual Disability ◯Frail Senior ◯Language Interpreter ◯Deaf/Hearing Impaired

Have you ever been arrested? ◯Yes ◯No If yes, how many times in past year?:_____

Emergency Contact: _____

Relationship:_____ Phone Number:_____

Address:_____

Does the client have a Primary Care Physician?: ◯Yes ◯No

Name of Provider and/or Facility: _____

Contact #: _____ Address:_____

Anything else you would like us to know?

_____

_____

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

Mental Health Treatment History

History of Past INPATIENT Psychiatric or Substance Use Treatment ☐ None ☐ Client Cannot Remember

Location	Dates	Reason for Hospitalization/Outcome	Release Obtained?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Current and Past OUTPATIENT Mental Health and/or Substance Use Treatment ☐None ☐ Unsure

Location	Dates	Reason for Treatment/Outcome	Release Obtained?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

CURRENT Medications (*include over the counter, herbals, vitamins, etc.)* ☐None ☐ Client Cannot Remember

Medication	Dosage/Duration	Prescriber	Is it helpful?	Release Obtained?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Other treatment info:_____

_____

_____

_____

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

Acknowledgements and Consent for Treatment

Acknowledgements and Consents for:
Provider Choice, Treatment, Use or Disclosure of Information for Treatment, Payment or Health Care Operations, Emergency Medical Care Rights and Responsibilities, Concerns, Complaints and Grievances, Outcome Measures, Follow Up, Release for Payment Purposes. Assignment of Benefits, Methods of Contacting

Provider Choice: I (or my **authorized representative [AR**]) understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for my Person-Centered Plan (counselor, case manager).

Treatment: I (or my authorized representative) consent to treatment by **Sand Dollar Wellness Center** or any agents (interns, case managers, counselors, contractors) in their employment or contract. **At all times, I retain the right to revoke this consent**

Authorization for Disclosure of PHI for treatment, payment and operations:
I (or my AR) consents to the use or disclosure of individually identifiable health information ("protected health information") by **Sand Dollar Wellness Center (SDWC)** in order to carry out treatment, payment, or health care operations. I have been advised of SDWC's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and my right to review such Notice prior to signing this consent form.
I have been advised that SDWC reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If SDWC does change the terms I may obtain a copy of the revised Notice by asking a staff member or by contacting the group's office manager/human resources at (910) 232-1328. I retain the right to request that **SDWC** further restricts how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. SDWC is not required to agree to such requested restrictions; however, if **SDWC** does agree to the requested restriction(s), such restrictions are then binding on SDWC**. At all times, I retain the right to revoke this consent**. Such revocation will be submitted to SDWC in writing. The revocation will be effective *except* to the extent that SDWC has already taken action in reliance on the consent. I may revoke this consent by giving written notice to a staff member or by sending a written notice to the group's office manager/human resources at 1136 Shipyard Boulevard Wilmington, NC 28412. SDWC may refuse to treat me if I do not sign this consent form (except to the extent that SDWC is required by law to treatment persons). If I (or authorized representative) sign this consent form and then revoke this consent, SDWC has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that SDWC is required by law to treat. Client has the right to refuse individualized treatments and/or treatment methods without fear of termination of services except as outlined in the statute. A printed copy of the statute (122C-57) is available upon request

Authorization for emergency treatment:
In case of an emergency, I (or my AR) authorize SDWC or contract agency staff to obtain emergency treatment from the person's physician or local hospital emergency room. I authorize the use of an ambulance and release of pertinent clinical information (written or verbal) to meet the needs of the emergency

Rights and Responsibilities:
I (or my AR) have reviewed the rights pamphlet "Your Rights and Responsibilities" that explains: Confidentiality, Responsibility, Grievance, Rights, Search and Seizure, and Suspension and Expulsion. I understand that I may ask questions for clarification if I have any questions or concerns. I understand I am entitled to my own physical copy of this if I choose. I also understand I may review the document at any time on SDWC website.

Concerns, Complaints and Grievances:
I (or my AR), have reviewed the pamphlet "Concerns, Complaints, and Grievances" that explains how to express concerns and make an official complaint or grievance. I understand that I may ask for clarification if I have any questions or concerns. I understand I am entitled to my own physical copy of this if I choose. I also understand I may review the document at any time on SDWC website.

Release of Information for Outcome Measures:
I (or my authorized representative), authorize SDWC to release all necessary information, as required by NC-TOPPS for the purpose of outcome measurement studies, including information pertaining to psychiatric and/or substance use, and/or HIV/AIDS related conditions and treatment.

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

Release of Information for Payment:
I (or my AR), allow SDWC to release all necessary portions of my clinical record, as required by the appropriate insurance company/3rd party payer for payment of services, including info pertaining to psychiatric and/or substance use, and/or HIV/AIDS related conditions and treatment.

Assignment of Benefits:
I (or my AR), authorize payment by the insurance company/third party payer directly to SDWC for services rendered, and/or payment of benefits to be applied to the public subsidy balance because of reduced ability to pay. I understand that I am financially responsible to SDWC for charges applied to the insurance deductible and for all charges limited by the insurance carrier. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fee and/or interest associated with the collection of the debt.

Allowed Methods of Contact:

During and after treatment I (or my authorized representative) allow SDWC to make contact with me in the following way(s): **check all that apply:**

Telephone: ◯Yes ◯No Ok to leave voice message on telephone: ◯Yes ◯No

Text Message: ◯Yes ◯No Physical Mail: ◯Yes ◯No Email: ◯Yes ◯No

Message with contact person? ◯Yes ◯No If yes: Name of Contact_____

I (or my AR), understand it is my responsibility to inform SDWC in writing when I desire changes in the method of contacting me.

Follow up:
I (or my AR), agree to be contacted after I leave services in order for SDWC to inquire about my current condition and satisfaction with services.
◯Yes ◯No

I (or my AR), have read and understand this information.
I am entitled to receive a copy of this form upon request and I am the person (or am authorized to act on behalf of the person) to sign this document verifying consent to all the above stated terms.

Date: _____ **Time:** _____ AM / PM

_____ _____
Signature of Client/Legal Guardian Signature of Witness

_____ _____
Print Name of Client/Legal Guardian Print Name of Witness

Please explain Guardian's Relationship to the client and include a description of Authority to act on behalf of the person:

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

Client Bill of Rights

- Each client has the right to impartial access to treatment, regardless of race, religion, sex, sexual preferences, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided
- Each client has the right to accept or refuse all or part of his/her care and/or have the expected consequences explained
- Each client has the right to expect that all treatment records or information will be kept confidential in compliance with agency policy except as authorized and as required by law. No information/records will be released without written permission of client or other appropriate designee, except to the physician, insurance company or hospital/facility client transferred to. The client will have access to all their health care records.
- Each client has the right to exercise personal privacy by withholding consent or family's or significant other's participation and to be informed of the possible consequences of that action
- Each client has the right to be informed of the nature and purpose of any services rendered and the title of personnel providing that service
- Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on their service provided and be aware of the process of voicing those grievances.
- It is the right of each client to receive individualized treatment which includes:
    - Adequate and humane services regardless of the source of financial support
    - Services provided in the least restrictive environment possible
    - An individualized treatment plan, which is reviewed periodically and as needed
    - To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate
    - Each client has the right to request a written copy of their treatment plan upon request.
- If at any time during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency – they have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.
- The client has the right to request a referral for services, which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.
- The client will be informed of his/her rights in a language they understand
- Each client has the right to refuse to participate in any research projects without compromising their access to the organizations resources
- Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.
- Each client has the right to make decisions regarding the withholding or resuscitative measures with these decisions respected per agency policy.
- Each client has the right to seek medical treatment for physical ailments.

I have read and understand the above Bill of Rights and I am aware that a copy is available to me upon my request.

Client/Legal Signature: _____ Date: _____

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

ACKNOWLEDGEMENT OF RECEIPT PRIVACY NOTICE

I hereby acknowledge I have reviewed of the Sand Dollar Wellness Center "PRIVACY NOTICE" packet. I have been offered a physical copy of this document upon request and been made aware it is located on SDWC's website at www.sanddollarwellnesscenter.com (Also, a physical copy located on the lobby corkboard for future reference).

I reviewed a copy of this material on the date indicated below.

Date: _____

_____
Client/Legal Guardian Signature

_____
Witness Signature

_____
Print Client/Legal Guardian Name

_____
Print Witness Name

KNOW YOUR RESOURCES

I acknowledge that I have been provided with information regarding the NCDHHS consumer handbook and how to make a complaint or grievance and the privacy notice. I have been offered a physical copy of this document upon request and been made aware it is located on SDWC's website at www.sanddollarwellnesscenter.com (Also, a physical copy located on the lobby corkboard for future reference). I understand that I have the right to contact any of the following entities at any time.

Trillium Health Resources: 877-685-2415

Disability Rights North Carolina: 877-235-4210

NC Division of MH/SU/DD Advocacy and Customer Services: 919-715-3197

Sand Dollar Wellness Center: 910-833-5902

Date: _____

_____
Client/Legal Guardian Signature

_____
Witness Signature

_____
Print Client/Legal Guardian Name

_____
Print Witness Name

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

Discharge Policy Notification Attestation

I have read and been given the opportunity to ask questions regarding Sand Dollar Wellness Center's Discharge Policy. I have been offered a physical copy of this document upon request and been made aware it is located on SDWC's website at www.sanddollarwellnesscenter.com (Also, a physical copy located on the lobby corkboard for future reference).

I understand that consistent engagement with recommended services is a vital part of my recovery. I understand that I must call at least 24 hours in advance to reschedule appointments. I understand that if I fail to show up for scheduled appointments without notice that I will be at risk of being discharged from all services at SDWC.

_____

Client/Legal Guardian Signature and Date

_____

Client/Legal Guardian Printed Name

Notification of Discharge Consent

I agree that Sand Dollar Wellness Center may mail my discharge letter, with instructions for engagement in services, to the address listed below:

Address: _____

_____

_____

Client/Legal Guardian Signature and Date

_____

Client/Legal Guardian Printed Name

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I _____ hereby authorize **Trillium Health Resources** to disclose specific health information from the records of the above-named client to: **Sand Dollar Wellness Center PC**

for the specific purpose(s) of: **NCTOPPS transfer**

Specific information to be disclosed: **NCTOPPS**

I understand that this authorization will expire on the following date, event or condition:

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requestor of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my records contain information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, substance use, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g. insurance company) for the sole purpose of creating health information (e.g. physical exam), service may be denied if authorization is not given. If treatment is research related, treatment may be denied if authorization is not given. I further understand that I may request a copy of this signed authorization

_____ _____

Signature of Client/Legal Guardian Date

_____ _____ _____

Printed Name of Client/Legal Guardian Date Relationship to Client

AUTHORIZATION was revoked on: Staff Initials: _____

SAND DOLLAR
WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

Consent to Bill Insurance

I hereby authorize Sand Dollar Wellness Center PC to furnish information to insurance companies concerning my treatment. I hereby assign Sand Dollar Wellness Center PC all payments for services rendered to myself and/or my dependents. I understand that verification of benefits does not guarantee payment from my insurance provider. (Please be aware that your insurance claim may take up to 30 days to process. You will be invoiced once your claim has been processed with your insurance company, and is due upon receipt, unless a prior written payment plan has been agreed upon.) I understand that I am responsible for any amount of service not covered by my insurance company. This will include, but not limited to, any deductibles, co-pays, co-insurance, and any denied services.

Payment is due to the time of service. We accept cash and all major credit cards. If you have insurance, the payment of your co-pay, deductible, and/or estimated patient portion is due at the time of service.

In signing this policy notice, I acknowledge that I have read and fully understand that I will be held responsible for any fees that my insurance company states not covered by policy or patient's responsibility.

Signature of Client or Legal Guardian:

_____

Date: _____/_____/_____

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

Financial Evaluation and Agreement Form

Primary Insurance Provider: _____

Insurance ID:_____ Subscriber Date of Birth:____/_____/_____

Subscriber Name if different than client: _____

Relationship to Subscriber: ◯Self ◯Dependent/Child ◯Spouse ◯ Legal Guardian ◯Other

Secondary Insurance Provide (if applicable):_____

Insurance ID:_____ Subscriber Date of Birth:____/_____/_____

Subscriber Name if different than client: _____

Relationship to Subscriber: ◯Self ◯Dependent/Child ◯Spouse ◯ Legal Guardian ◯Other

If you are unable to afford your appointments you may be eligible for sliding scale rates. Please provide the following information so we may consider you for this option.

Reported Monthly Income Amount for family: $_____

Number of individuals in the family: _____

To be complete by SDWC office staff

Staff verified Insurance: ◯Yes ◯No ◯Self Pay Staff Initials:_____

Eligible for Sliding Scale?: ◯Yes ◯No Signed Sliding Scale Agreement: ◯Yes ◯No

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

45 C.F.R. Parts 160 and 164; 42 C.F.R Part 2; G.S. 122C

This authorization form implements requirements for individual authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R, Part 2), and the state confidentiality law governing mental health, developmental disabilities and substance use services (G.S. 122C).

I, _____ (DOB:) _____authorize Sand Dollar Wellness Center &

Emergency Contact - _____to communicate with and disclose to one another.

THIS INFORMATION/DATA WILL INCLUDE:

- ⊗ ASSESSMENTS
- ⊗ SUBSTANCE USE INFORMATION
- ◯ HIV/AIDS INFORMATION
- ⊗ PSYCHOLOGICAL EVALUATIONS
- ⊗ PSYCHIATRIC EVALUATIONS
- ⊗ SOCIAL HISTORY AND INFORMATION
- ⊗ SERVICE NOTES
- ⊗ DEVELOPMENTAL INFORMATION
- ⊗ MEDICAL INFORMATION
- ⊗ SERVICE PLANS/GOALS
- ⊗ DISCHARGE SUMMARY

◯ OTHER: _____

PURPOSE OF USE OR DISCLOSURE:

- ⊗ AT THE REQUEST OF THE INDIVIDUAL
- ⊗ ASSESSMENT/EVALUATION
- ⊗ COORDINATION OF SERVICES
- ◯ COURT PROCEEDINGS
- ◯ DETERMINATION OF BENEFITS
- ◯ OTHER: _____

REDISCLOSURE:

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R Part 2), protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance use treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws. Our Privacy Policy describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke authorization, as well as the exceptions of my right to revoke, are explained in the Sand Dollar Wellness Center Privacy Practices, a copy of which has been given to me.

If not revoked, this consent shall be valid for 1 YEAR from the date signed unless otherwise indicated here:

_____

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this form. I understand that Sand Dollar Wellness Center will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____
Client/Legal Guardian Signature

_____
Staff Signature

_____
Date

_____
Date

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
45 C.F.R. Parts 160 and 164; 42 C.F.R Part 2; G.S. 122C

This authorization form implements requirements for individual authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R, Part 2), and the state confidentiality law governing mental health, developmental disabilities and substance use services (G.S. 122C).

I, _____ (DOB:) _____authorize Sand Dollar Wellness Center,

and **Primary Care Provider** _____to communicate with and disclose to one another.

THIS INFORMATION/DATA WILL INCLUDE:

- ⊗ ASSESSMENTS
- ⊗ SUBSTANCE USE INFORMATION
- ◯ HIV/AIDS INFORMATION
- ⊗ PSYCHOLOGICAL EVALUATIONS
- ⊗ PSYCHIATRIC EVALUATIONS
- ⊗ SOCIAL HISTORY AND INFORMATION
- ⊗ SERVICE NOTES
- ⊗ DEVELOPMENTAL INFORMATION
- ⊗ MEDICAL INFORMATION
- ⊗ SERVICE PLANS/GOALS
- ⊗ DISCHARGE SUMMARY

◯ OTHER: _____

PURPOSE OF USE OR DISCLOSURE:

- ⊗ AT THE REQUEST OF THE INDIVIDUAL
- ⊗ ASSESSMENT/EVALUATION
- ⊗ COORDINATION OF SERVICES
- ◯ COURT PROCEEDINGS
- ◯ DETERMINATION OF BENEFITS
- ◯ OTHER: _____

INFORMATION REQUESTED SHOULD BE FAXED TO THIS Number: 910-833-5905

REDISCLOSURE:

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R Part 2), protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance use treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws. Our Privacy Policy describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke authorization, as well as the exceptions of my right to revoke, are explained in the Sand Dollar Wellness Center Privacy Practices, a copy of which has been given to me.

If not revoked, this consent shall be valid for 1 YEAR from the date signed unless otherwise indicated here:

_____

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this form. I understand that Sand Dollar Wellness Center will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____

Client/Legal Guardian Signature

Staff Signature

_____ _____

Date

Date

SAND DOLLAR WELLNESS CENTER

Client Name:_____

DOB: _____ MRN: _____

Insurance: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

45 C.F.R. Parts 160 and 164; 42 C.F.R Part 2; G.S. 122C

This authorization form implements requirements for individual authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R, Part 2), and the state confidentiality law governing mental health, developmental disabilities and substance use services (G.S. 122C).

I, _____ (DOB:) _____authorize Sand Dollar Wellness Center &

Trillium Health Resources **to communicate with and disclose to one another.**

THIS INFORMATION/DATA WILL INCLUDE:

⊗ ASSESSMENTS	⊗ PSYCHOLOGICAL EVALUATIONS	⊗ DEVELOPMENTAL INFORMATION
⊗ SUBSTANCE USE INFORMATION	⊗ PSYCHIATRIC EVALUATIONS	⊗ MEDICAL INFORMATION
◯ HIV/AIDS INFORMATION	⊗ SOCIAL HISTORY AND INFORMATION	⊗ SERVICE PLANS/GOALS
	⊗ SERVICE NOTES	⊗ DISCHARGE SUMMARY

◯ OTHER: _____

PURPOSE OF USE OR DISCLOSURE:

⊗ AT THE REQUEST OF THE INDIVIDUAL ⊗ ASSESSMENT/EVALUATION ⊗ COORDINATION OF SERVICES

◯ COURT PROCEEDINGS ◯ DETERMINATION OF BENEFITS

◯ OTHER: _____

INFORMATION REQUESTED SHOULD BE FAXED TO THIS Number: **910-833-5905**

REDISCLOSURE:

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R Part 2), protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance use treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is prohibited except as permitted or required by these two laws. Our Privacy Policy describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke authorization, as well as the exceptions of my right to revoke, are explained in the Sand Dollar Wellness Center Privacy Practices, a copy of which has been given to me.

If not revoked, this consent shall be valid for 1 YEAR from the date signed unless otherwise indicated here:

_____

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this form. I understand that Sand Dollar Wellness Center will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____

Client/Legal Guardian Signature Staff Signature

_____ _____

Date Date