MONARCH

Name: **Medicaid ID #:** **DOB:** **Record Number:**

CONSENT FOR RELEASE OF INFORMATION

1. Name/Address/Telephone/Fax (as applicable) of Agency or Individual Which Possesses Information to be Released/Exchanged:	2. Name/Address/Telephone/Fax (as applicable) of agency or individual to whom information is to be released/exchanged.

3. I hereby request and authorize the above named agency, organization or individual, which possesses information relative to the person named above to release/exchange information to the agency, organization or individual named. I understand that the information to be released/exchanged may include information regarding drug/alcohol abuse, sickle cell anemia, tuberculosis, psychological or psychiatric impairments, and/or HIV/AIDS information. If authorization is required to release HIV/AIDS information, please specify that such information is being released. HIV/AIDS information or related conditions are only disclosed in accordance with the communicable disease laws (GS 130A-143).

4. The information to be released shall include: (nature and extent of data to be released): _____
_____

5. Specific purpose of release: _____
6. Specific Dates: _____
7. If not revoked earlier, this consent expires automatically on _____or one year from the date it is signed, whichever is earlier.

8. Other Information: _____
_____

9. Informed consent to release information has been explained to me, and I understand the contents to be released/exchanged, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and I understand that I may request a copy of the signed consent.

10. I understand that treatment/habilitation/services, payments, enrollment, or eligibility for benefits may not be conditioned on obtaining the consent/authorization as such conditions is prohibited by federal and state rules. I further understand that I may revoke this consent/authorization in writing at any time except to the extent that action has been taken. I understand that the HIPAA Privacy Law (45 C.F.R Part 164) protecting health information may not apply to the recipient of this information, and therefore, may not prohibit the recipient from disclosing it. Upon disclosure of mental health and developmental disabilities information protected by State Law GS 122-C or substance abuse treatment information protected by Federal Law 42 C.F.R. Part 2, Monarch informs the recipient of the information that **re-disclosure is prohibited except as permitted or required by these laws.** The actual law states the following:

***This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug use patient.*

_____ _____
Signature of Individual Served Date

_____ _____ _____
Signature of Legally Responsible Person Relationship to Individual Served Date

_____ _____ _____
Print Name of Legally Responsible Person Signature of Witness (*required only if signature is an 'X', mark or symbol)* Date

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RE-DISCLOSURE OF OBTAINED OR RELEASED INFORMATION IS PROHIBITED WITHOUT CONSENT OF THE PERSON NAMED ABOVE.

REVOCATION: My signature below indicates I am providing written notice that this consent to release/exchange information by Monarch is being revoked. No further action will be taken on my previously signed consent except to the extent that action has already been taken.

Signature of Individual Served	Date	
Signature of Legally Responsible Person	Relationship to Individual Served	Date
Print Name of Legally Responsible Person	Signature of Witness (*required only if signature is an 'X', mark or symbol)*	Date