ALBERTA PROFESSIONAL SERVICES, INC

AUTHORIZATION TO EXCHANGE PROTECTIONED HEALTH INFORMATION

RELEASE/REQUEST SECTION

Pursuant to 10A NCAC 26B .0202 (a)

(1) Client Name _____ Medical Record #_____

Medicaid #: _____ I _____ hereby authorize
(Client or Personal Representative)

(2) Alberta Professional Service, to disclose or receive, specific health information from the records of the above named client to:

(3) _____
(Recipient Names)

(4) Specific information to be disclosed: _____

_____

(5) for the specific purpose: _____

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

_____

(7) 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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

(8) _____
(Signature of Client or Legally Responsible Person)

(9) _____
(Date Signed)

Pursuant to 10A NCAC 26B .0202(e), G.S. 130A-143, and 42 CFR Part 2

I understand that if I want included in my record any information relating to the items listed below I must give individual consent for each item by checking the box.

☐ **HIV infections, AIDS or AIDS-related conditions,**
☐ **alcohol abuse, drug abuse,**
☐ **psychological or psychiatric conditions, or**
☐ **genetic testing this disclosure will include that information.**

Pursuant to 10A NCAC 26B .0202(b)

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 the disclosures for financial transactions, wherein the authorization is valid indefinitely.

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

Pursuant 10A NCAC 26B .0202(d)

I understand that a clear and legible photocopy of consent for release of information shall be considered to be as valid as the original.

I further understand that I may request a copy of this signed authorization.

ALBERTA PROFESSIONAL SERVICES, INC

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Client) *(Date)* *(Signature of Agency Representative)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any action taken on this
(Date)

authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Client) *(Date)* *(Signature of Agency Representative)* *(Date)*

If client/guardian chooses to withdrawal their consent, make sure relevant APS personnel are aware of this change.

This forms meets these standards
Authority: 10A NCAC 26B .0202(b)(d)(e); G.S. 130A-143; 42 CFR Part 2; CARF 2013 BH 2.G.1.b, 2.G.4.k