FOR OFFICE USE ONLY
rec'd by ____________/ /__________
completed by __________ / ________

CARTERET CLINIC FOR ADOLESCENTS AND CHILDREN

Authorization for Exchange of Confidential Information

Patient Full Name:____

Patient Date of Birth:____

Person, Agency or School

Name of agency/school_______________________________________

Contact person____

Address____

City/State/Zip____

Phone number/ fax number_____________________________________

I hereby give authorization for the exchange of confidential information between the above entity or person and **Carteret Clinic for Adolescents and Children.** The purpose for which information is to be exchanged may include medical and/or educational planning, placement, progress, or referral information. This consent will be in effect for one year from date of signature and can be revoked at any time by written signature.

You have the right to exclude information about substance abuse, and HIV/AIDS-related information. This information is protected by Federal confidentiality rules (42 CFR part 2 and 130-A143). The rules prohibit us from making any further disclosure of information unless further disclosure is expressly permitted by your written consent.

YES, DISCLOSE THIS INFORMATION: I give consent to release information about **HIV/AIDS.**

Signature: ____ Date:______________

YES, DISCLOSE THIS INFORMATION: I give consent to release information about **substance abuse.**

Signature: ____ Date:______________

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Parent/legal guardian signature:______________________________ DATE:________________

Please PRINT name:____

Witness:____ DATE:________________

REVOCATION OF AUTHORIZATION

REVOKED ON (DATE):_________________________

BY (PRINT NAME)____

Signature:____

LKF 05-04-2016