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

CARTERET CLINIC FOR ADOLESCENTS AND CHILDREN

FOR OUR PATIENTS 18 YEARS OLD and OVER

Authorization for Exchange of Confidential Information

Patient Full Name:____

Patient Date of Birth______________________________ Your phone #______________________

Parent or Legal Guardian(s)

Name and relationship to patient____

Address____

City/State/Zip____

Phone number____

Name and relationship to patient____

Address____

City/State/Zip____

Phone number____

I hereby give authorization for the exchange of confidential information between the above named 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 until revoked in writing.

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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Patient signature:______________________________________ DATE:__________________

Please PRINT name:____

Witness:____ DATE:__________________

REVOCATION OF AUTHORIZATION

REVOKED ON (DATE):______________________BY (PRINT NAME)______________________

Signature:____

LKF 12-13-2016