To Whom It May Concern:

Thank you for your interest in our Transitional Apartment Program. Please complete the enclosed application, and Authorization to Share/Release information to list your respective Mental Health Provider and or Care Coordinator. You may return the completed application, authorization form, and a recent copy of your criminal background check by mail or fax to the program. You will be contacted for an interview thereafter *if* selected as a candidate to the program. Please note entry into the program is a process that requires approval by the TAP program and also property management. You will be notified upon completion of your interview, and additional items will be requested at the point and time you are selected as a candidate to the program.

We thank you for your interest in the TAP program and please call if you have any questions.

Sincerely,

Deborah Tuggle
Program Director TAP TBI/SPMI programs
Lutheran Family Services
5712 Shattalon Drive, Apt #47
Winston-Salem, NC 27105
336-744-7350
336-744-7351 fax

LUTHERAN SERVICES CAROLINAS

AUTHORIZATION FOR RELEASE/EXCHANGE OF CLIENT INFORMATION

CLIENT NAME:	**RECORD NUMBER:**

This authorization form implements the requirements for client 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 state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122 C).

I, _____ authorize _____

Name of client or client's legally responsible person *Person and agency authorized to use and disclose the information*

to use or disclose to/with _____

Name of person and agency to whom the requested use or disclosure will be made (include address, if applicable)

THIS DATA SHALL INCLUDE *(client must initial beside data to be used or disclosed)*

____ Assessments	____ Service Notes	____ Substance Abuse/Treatment
____ Psychiatric Evaluations	____ Service Plans/Goals	____ HIV/AIDS Information
____ Psychological Evaluations	____ Discharge Summary	____ Social, Developmental, Medical History
____ Diagnoses	____ Financial/Reimbursement	
____ Other: _____		

PURPOSE OF USE OR DISCLOSURE *(client must initial beside data to be used or disclosed)*

____ At the request of the individual	____ Assessment/Evaluation	____ Coordination of Service
____ Court Proceedings	____ Determination of Benefits	____ Other _____

Information requested should be mailed to this address: _____

_____

_____

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse 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 Notice of Privacy Practices 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. Upon request, the procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke will be provided to me upon request. These procedures are explained in Lutheran Family Services' Notice of Privacy Practices, a copy of which will be given to me upon request.

If not revoked earlier, this consent shall be valid for 90 days for one time releases or one year when the release is required for ongoing service provision, from the date signed unless otherwise indicated below:

_____ _____

Date of expiration (90 days/one year) ***Event, if less than 90 days/one year***

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that Lutheran Family Services will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____ _____

Signature of client **Date** **Witness (required if symbol or mark is used by client or LRP)**

_____ _____

Signature of legally responsible person, if required **Date**

Please explain LRP authority to act on behalf of the client: _____

Staff Signature

☐ **Power of Attorney** ☐ **Guardian** ☐ **Other** _____

☐ **A copy of this consent was given to the client** **(client initials verifying receipt):** _____

FILE IN RECORD WITH OTHER CONSENTS/ COPY TO CLIENT

Dev. 4/03 (Rev. 10/06)