CONSENT TO RELEASE INFORMATION

CLIENT: **DATE OF BIRTH:**	**The client must always be given a copy of this form after signing.**

The Crisis Navigation Project is a project focused on promoting the use of psychiatric advance directives (PADs) by providing community education and training community members how to facilitate the creation of PADs. The project is based at Southern Regional Area Health Education Center in Fayetteville, NC. To ensure the quality of the training that we provide, we have a quality assurance process that requires the Crisis Navigation Project team to review completed psychiatric advance directives and to discuss the process of facilitation with the person who helped you create a PAD. The Crisis Navigation Team also includes colleagues at Duke University Medical Center. The purpose of this form is to provide your consent to allow review of your PAD and the facilitation process for quality assurance purposes only.

I**,** [print name]_____**,** hereby authorize release of information to/from:

- Barbara B. Smith, LCSW, Project Coordinator, Southern Regional AHEC, Fayetteville, NC 28404
- _____
- _____
- _____

Please **initial** below indicating which information regarding your treatment may be exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

_____ I authorize the release of information in my psychiatric advance directive for quality assurance purposes.

_____ I authorize the release of information about the process of facilitation of my psychiatric advance directive.

_____ Other (specify) _____

Southern Regional AHEC Area Health Education Center

CONSENT TO RELEASE INFORMATION

CLIENT:

DATE OF BIRTH:

I understand what information will be released, the purpose for the release of the information, and that there are statutes and regulations protecting the confidentiality of the information to be released. I understand further that the federal privacy law (45 CFR Part 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.

I understand the terms of this release and voluntarily give my authorization. I understand that I may refuse to sign this authorization form and understand that facilitation or creation of a psychiatric advance directive will not be conditioned by my signature on this authorization.

I further understand that I may revoke my authorization by giving written notice to Southern Regional AHEC, 1601 Owen Dr., Fayetteville, NC 28304). Such revocation does not affect the validity of the consent for information disclosed prior to the revocation. If not revoked earlier, this authorization expires automatically one year from the date it is signed or upon _____, whichever is earlier. *(date or event specified by client or dictated by the purpose of the authorization)*

I have read and understand the information in this Consent to Release Information form.

Signed _____ Date _____
(Specify if signature is that of client, parent(s), legal guardian, or personal representative)

If not signed by client, explain representative's authority to act on behalf on client:

_____

Witnessed _____ Date _____
*(Witness signature is required only if the form is sent out of state **or** if the above client signature has been signed by a mark)*

This authorization is hereby revoked upon the signed and dated request of the client as noted below:

Signed _____ Date _____
(Client signature)

The client has notified me verbally that s/he wishes to revoke this authorization with an effective date of

_____ *(Effective date)***.**

Signed _____ Date _____
(Staff signature)

THE INFORMATION RELEASED IS CONFIDENTIAL AND REDISCLOSURE IS PROHIBITED EXCEPT AS SPECIFICALLY AUTHORIZED BY STATE OR FEDERAL LAW.