CARTERET CLINIC FOR ADOLESCENTS AND CHILDREN

 FOR OUR PATIENTS 18 YEARS OLD and OVER

Authorization for Exchange of Confidential Information—**HEALTH CARE PROXY**

Patient Full Name:

Patient Date of Birth Patient phone #

Patient Address

City/State/Zip

Patient EMAIL:

I hereby give authorization for the exchange of confidential information between the following **HEALTH CARE PROXY** 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.

**Proxy Full Name**

**Proxy Gender Proxy Date of Birth**

Address

City/State/Zip EMAIL

Phone number relationship

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.**

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| --- |
| FOR OFFICE USE ONLYrec’d by \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_completed by \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ |

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: