AUTHORIZATION FOR RELEASE OF INFORMATION

1. From Organization (Check One):

☐ Kellin, PLLC Client
2110 Golden Gate Drive, Suite B
Greensboro, North Carolina 27405
Phone: 336-355-6206

☐ Kellin Foundation Client
2110 Golden Gate Drive, Suite B
Greensboro, North Carolina 27405
Phone: 336-429-5600 Fax: 336-429-5600

To: Organization: ____ (Name)
Address: __________________________________ City: _________________ State: ________ Zip: _______
Phone: (___)_________________ Fax: (___)________________

3. I consent to the above-named agencies, organization or individuals to release, exchange, and /or communicate with one another the information that is listed below. I understand that the information released may include information regarding HIV/AIDS.

4. This data shall include:
   ____ Screening and /or Admission Assessment Evaluation
   ____ Treatment (Service) Plan / Diagnosis
   ____ Discharge Summary
   ____ Cases Management Assessment / Plan
   ____ Psychiatric and /or Psychological Evaluation
   ____ Psychotherapy Notes (*note – this requires a separate authorization form)*
   ____ Treatment report from other agencies / persons (specify): ______________________________
   ____ Medication History
   ____ Other____

5. Client must initial if any of the above data contains substance abuse information:
   ____ I understand that my records are protected under the federal regulations governing the confidentiality of Alcohol and drug abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. By my initials here, I consent to the sharing of this information within my record.

6. I understand this information will be used for: ____
   ____
   ____

7. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent will terminate upon __________________________ (mm/dd/yy) (not to exceed one year from date of signature), or specified event or condition ____________________________ _________________________ of whichever is earlier.

____ _________________________________
Client Date

____ _________________________________
Legally Responsible Person (when required) Date

NOTE: In case of minor receiving substance related services, the minor must always sign the Authorization for Release of Information, and when applicable, the legally responsible person.

Printed Name: ____
Address: _________________________________ **City:** _________________ **State:** ________ **Zip:** _____
DOB: ____________________________________ **Phone:** (___)____________________