CONSENT
FOR RELEASE OF INFORMATION FORM

The Unique Caring Foundation
5500 Executive Center Drive
Suite 118
Charlotte, N.C. 28212

Consumer:	**RECORD#:**	**DATE:**

I, _____ (Client/Guardian) hereby authorize Mecklenburg County Area Mental Health Authority to release all information checked below to: The Unique Caring Network

- ✓ Summary of Evaluation & Treatment
- ✓ Psychological Evaluation
- ✓ Educational Information
- ✓ Medication History
- ✓ Intake Information
- ✓ Progress Notes
- ✓ Financial Information
- ✓ Psychiatric Evaluation & History

This consent is valid for one year from _____ to _____.

I understand this information will be used for:

- ✓ Evaluation & treatment planning
- ✓ Referral

The doctrine of informed consent for release of information has been explained to me and I understand contents to be released / exchanged, the need for information, and that there are statutes and regulations protecting the confidentiality of authorized information. I herby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ **OR** _____
(Consumer) (Legally Appointed Representative)

_____ _____
(Date) (Witness)

Revised 7/10/05

CONSENT FOR SERVICES FORM

The Unique Caring Foundation
5500 Executive Center Drive
Suite 118
Charlotte, NC 28212

Consumer:	**RECORD#:**	**DATE:**

1. I request admission for evaluation, treatment or habilitation. Should staff determine that admission for services is appropriate, I consent for treatment as deemed necessary. I understand that I may withdraw from services at any time unless ordered by a court of law to attend.

2. I authorize The Unique Caring Foundation staff to seek emergency medical or dental care in the event that I become ill or have an accident while participating in services. This shall include emergency first aid by authorized personnel for the agency. I further understand that I will assume financial responsibility for any necessary medical care, including payment of physician, emergency room and rescue unit charge.

3. I understand that certain information from my record may be contained in a computerized record system for reimbursement, statistical and program planning purposes.

4. I understand that as a consumer of services from a contract affiliate agency of the Area Mental Health/Developmental Disabilities/Substance Abuse Services and/or Youth and Family Services, I shall receive appropriate treatment and continuity of care. In order to accomplish this, information may be shared between treating agencies for quality care without consent in accordance with G.S. 122C-52 through 122C-56.

5. Consumer records relating to substance abuse are protected by Federal Confidentiality rules (42CFR Part 2). The Federal Rules prohibit this agency or its staff from making any disclosure regarding the person to medical or other information **IS NOT** sufficient for this purpose.

6. If I participate in a supervised program activity which involves transportation, I consent to be transported and hold The Unique Caring Foundation and its staff harmless in case of accident or injury.

7. I have received a copy of The Unique Caring Foundation Consumer Rights and Responsibilities Handbook, which contains a summary of my rights as a consumer as defined in G.S. 122C, Article 3. The contents of the Handbook were explained to me, especially rules I am expected to follow, how to obtain a copy of my treatment plan, and how to file a consumer grievance. I was informed how to contact the Governor's Advocacy Council for Persons with Disabilities and local advocacy groups. I understand this information as explained to me.

The doctrine of informed consent for services has been explained to me and I understand contents to be released / exchanged, the need for information, and that there are statutes and regulations protecting the confidentiality of authorized information. I herby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ _____

(Client) (Legally Appointed Reprehensive)

_____ _____

(Witness) (Date)

Revised 7/10/05