**EAGLE PSR REFERAL FORM** (Date:\_\_\_\_\_\_\_\_\_\_\_\_ )

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County of Medicaid:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WCHS MR#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer’s address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client live in a group home Y:\_\_\_\_\_ N:\_\_\_\_\_

Group Home Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Home Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for referral/Other information you’d like us to know:

Please check any areas of skill development that would apply:

\_\_\_\_ Social Skills, Relational Skills, Adaptation Skills

\_\_ \_ Communication Skills

\_\_ \_ Conflict Resolution Skills, Anger Management, other Behavior Management

\_\_ \_\_Independent Living Skills and/or Functional Skills

\_\_ \_ Daily and/or Community Living Skills

\_\_ \_ Self-advocacy

\_\_\_\_ Parenting Skills

\_\_ \_ Coping Skills/Symptom Management

\_\_\_\_ Other:

Date of last clinical/diagnostic assessment that provides all 5 axis with justification for diagnosis: \_\_\_\_\_

Name of person/agency submitting referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Relationship to consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact # for person submitting referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*Please include with referral form:

* diagnostic or clinical assessment providing diagnosis and recommendation for PSR (If either of these is not included, the client must first be scheduled for intake with one of our licensed clinicians and psychiatrist.)
* service plan, PCP, goals currently being worked on and persons working with the consumer (i.e.; group home, psychiatrist)
* signed consent release of information

**Acknowledgement of Consumer Choice Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(consumer, guardian) acknowledge that I have been given an opportunity to review a list of Endorsed Service Providers and the services they provide within Wake County. I understand that only medically necessary services will be authorized. I have been informed of the appropriate and available providers in the WCHS LME Provider Network that would meet my specific needs for services, location, and hours of availability.

I understand it is my choice to select an Endorsed Services Provider to address my needs and that I can cancel my services provider if I would like to make a change. I can also call Consumer Rights at (919) 212-7155 to request assistance if I experience any difficulty with changing my service provider.

**Please check the appropriate box below to indicate your selection(s).**

* I do not have a preference of Service Providers and understand that I will be referred to the next appropriate Service Provider on the Wake County LME intake referral list for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (services).
* I choose to receive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(services) from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(agency/agencies) and understand that someone from the agency/agencies will be contacting me within 7 days from the date of my signature on this form to imitate the service process.
* I chose to wait for the first available appointment/vacancy for \_\_\_\_\_\_\_\_\_\_\_\_\_\_(services) to be provided by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(agency/agencies). I have received procedures for accessing crisis services and understand the rise of delaying services.
* I choose to decline\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_services at this time. I have received procedures for accessing services and understand the risk of declining these services.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Program witness)

**INFORMED CONSENT FOR TREATMENT – ADULT**

**Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client No: \_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of legal guardian: Program:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROGRAM: I agree that I have received an explanation of Eagle rules, expectations, and program availability. I consent to receive PSYCHOSOCIAL REHABILITATION services from Eagle. I understand and agree that I will participate in this service voluntarily and that this consent may be withdrawn with written consent at any time.**

**CLIENT RIGHTS: I have received a copy of my Client rights, Client Handbook, a copy of HIPAA Privacy/confidentiality Notice and have had adequate time and opportunity to ask questions and receive answers.**

**INTERVENTIONS: I agree to allow the staff of Eagle to implement professional best practice accepted methods of interventions indicated by the therapeutic, comprehensive treatment goals and plan that both the program and I have mutually agreed upon. I understand that the potential benefits of any service or combination of services are directly impacted by my participation and motivation. There is evidence that these services are effective in improving functioning and decreasing symptoms of mental illness, but there is not a guarantee for my success. I also understand that there are other treatment providers and services available and that Eagle may refer me to one of these (with my written consent) if it is determined by me or that I would gain greater benefit from an alternate provider or service. I understand that upon agreement to receive services, I am providing my consent for Eagle to communicate with required federal, state and county agencies and authorizing bodies as necessary for Eagle to maintain compliance with those regulations and to maintain my services that I have consented to participate with.** **I understand that failure to receive treatment poses a risk that my symptoms may not improve or worsen. It is rarely possible that some therapeutic interventions could worsen my condition. Only non-physical crisis interventions will be used for the purpose of preventing a client from harming him/herself and never as a form of punishment and carried out duly by a trained and certified staff member.**

**EMERGENCY CARE: I Authorize Eagle to obtain emergency medical, dental or mental health care on me if I am unable to do so myself.**

**FIRST AID: I authorize Eagle to provide and render first aid to me as deemed necessary by trained and certified staff.**

**AMENDMENTS: I understand that this consent may be amended on an “as needed” basis and that I will need to sign any amendments or, if legally declared incompetent, the signature of my legal guardian.**

**AMENDMENTS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACCEPTANCE: I (we) have read and/or have had clearly explained to me the terms, conditions and agreements this informed consent agreement and voluntarily accept these terms as stated or amended as specified. This agreement may be withdrawn at any time and will not exceed one year after the date it was signed.**

**Expiration of Informed Consent for Service Delivery (not to exceed 1 year)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT CONSENT FOR TRANSPORTATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby give permission to staff of Eagle PSR to transport myself, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as needed for treatment, clinical interventions, outings and appointments.

The specific arrangements of such transportation have been fully explained to me and I recognize that I may revoke transportation consent at any time.

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR PICTURE USE**

Consumer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Record #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my consent to Eagle PSR to take my picture (**for internal use only**), for the following purpose:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that no other use of these pictures will be made without my additional consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT CLIENT’S NAME DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S SIGNATURE (Parent or Guardian) DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Refuses to Acknowledge Receipt or Sign

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Member DATE

**ACKNOWLEDGEMENT OF PRIVACY PRACTICE**

I acknowledgement that I have received a copy of the Notice of Privacy Practices of Eagle PSR. That explains how Eagle PSR can disclose my confidential information. I have been given an opportunity to read this notice and ask question of Eagle PSR staff. I also understand that if I should have any questions about this Notice or about my Privacy Rights, I can contact Eagle PSR at (919) 896-6938.

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTIFICATION OF MONEY MANAGEMENT POLICY**

I acknowledge and agree to adhere to Eagle PSR policy on the management of client funds. I understand that clients are responsible for their own personal funds. I also understand that Eagle PSR will not at any time have any dealings with client’s personal funds. I also understand that if I should have any questions regarding this policy, I can contact Eagle PSR at (919) 896-6938.

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Property Destruction**

I have read and understand Eagle PSR policy on property destruction. I acknowledge and agree to adhere to this policy. I understand that any property destruction incident may result in PSR terminated services. I also understand that if I should have any questions regarding this policy, I can contact Eagle PSR at (919) 896-6938.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT CLIENT’S NAME DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S SIGNATURE (Parent or Guardian) DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Refuses to Acknowledge Receipt or Sign

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Member DATE

**Notice of Suspension and Expulsion**

I have read and understand Eagle PSR policy on suspension and expulsion. I acknowledge and agree to adhere to this policy. I understand that incidents will be evaluated on a case by case basis and reviewed by the Management Team before a decision is made. I understand that I will be notified in writing about any decision, at which point I can appeal the decision. I also understand that if I should have any questions regarding this policy, I can contact Eagle PSR at (919) 896-6938.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT CLIENT’S NAME DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S SIGNATURE (Parent or Guardian) DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Refuses to Acknowledge Receipt or Sign

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Member DATE

**AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION**

|  |
| --- |
| **The cl The client must always be given a copy of this form after signing. In the following cases, minors have the right to release** **Information without a parent’s signature if: 1) Emancipated minors, 2) Minors receiving Substance Abuse Treatment** |

To/From; circle one.

Person/Agency Address Phone No. Fax

 **Alliance Health\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 For the purpose of assessment, treatment planning, referral, and/or coordination of services.

Please **check** below indication which documentation regarding your treatment may be released or exchanged.

|  |
| --- |
| \_\_\_\_\_**Evaluation(s) (psychiatric, psychological, diagnostic reports) \_\_\_\_\_\_Medication History/Physicians Orders****\_\_\_\_\_Psychiatric Evaluation(s) \_\_\_\_\_\_Assessments(s) type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Service Note(s) dates:\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insurance Information****\_\_\_\_\_Transfer/Discharge Summary \_\_\_\_\_\_Educational/Social/ Developmental History** **\_\_\_\_\_Treatment Plan and Diagnosis \_\_\_\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Release of record is authorized for records containing substance abuse/use** **\_\_\_\_\_Release of record is authorized for records containing HIV/AIDS.****\_\_\_\_\_Periodic exchange of information between Eagle Psychosocial Rehabilitation Program and the noted agency.** |

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting

health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws,

however, may prohibit redisclosure. I understand that the information to be disclosed may include information regarding drug, abuse, and alcohol

abuse, HIV infection, AIDS or AIDs related conditions. When we disclose mental health and developmental disabilities information protected by

state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the

information that redisclosure is prohibited except as permitted or required by the laws.

I understand that I may revoke this authorization at any time unless this authorization is given as condition of obtaining insurance coverage and

the insurer has a legal right to contest the policy or claim under the policy. Such revocation does not affect the validity of the consent for

information disclosed/released prior to the revocation. In any event, if not revoked earlier this authorization expires automatically one year

(365 days) from signature date.

I understand that I may refuse to sign this authorization form. I understand that **Eagle Psychosocial Rehabilitation Program** willbegin and

continue client’s treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely,

voluntarily, and without coercion. I understand health insurance and information, indicated by initials, will be disclosed.

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Responsible Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement**

**requesting revocation signed and dated by the above name person or guardian**.

Consumer/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **The client** notified **me verbally that he/she wishes to revoke this authorization with an effective date of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION**

|  |
| --- |
| **The cl The client must always be given a copy of this form after signing. In the following cases, minors have the right to release** **Information without a parent’s signature if: 1) Emancipated minors, 2) Minors receiving Substance Abuse Treatment** |

To/From; circle one.

Person/Agency Address Phone No. Fax

 **Group Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 For the purpose of assessment, treatment planning, referral, and/or coordination of services.

Please **check** below indication which documentation regarding your treatment may be released or exchanged.

|  |
| --- |
| \_\_\_\_\_**Evaluation(s) (psychiatric, psychological, diagnostic reports) \_\_\_\_\_\_Medication History/Physicians Orders****\_\_\_\_\_Psychiatric Evaluation(s) \_\_\_\_\_\_Assessments(s) type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Service Note(s) dates:\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insurance Information****\_\_\_\_\_Transfer/Discharge Summary \_\_\_\_\_\_Educational/Social/ Developmental History** **\_\_\_\_\_Treatment Plan and Diagnosis \_\_\_\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Release of record is authorized for records containing substance abuse/use** **\_\_\_\_\_Release of record is authorized for records containing HIV/AIDS.****\_\_\_\_\_Periodic exchange of information between Eagle Psychosocial Rehabilitation Program and the noted agency.** |

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting

health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws,

however, may prohibit redisclosure. I understand that the information to be disclosed may include information regarding drug, abuse, and alcohol

abuse, HIV infection, AIDS or AIDs related conditions. When we disclose mental health and developmental disabilities information protected by

state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the

information that redisclosure is prohibited except as permitted or required by the laws.

I understand that I may revoke this authorization at any time unless this authorization is given as condition of obtaining insurance coverage and

the insurer has a legal right to contest the policy or claim under the policy. Such revocation does not affect the validity of the consent for

information disclosed/released prior to the revocation. In any event, if not revoked earlier this authorization expires automatically one year

(365 days) from signature date.

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continue client’s treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely,

voluntarily, and without coercion. I understand health insurance and information, indicated by initials, will be disclosed.

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Responsible Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement**

**requesting revocation signed and dated by the above name person or guardian**.

Consumer/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **The client** notified **me verbally that he/she wishes to revoke this authorization with an effective date of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION**

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| **The cl The client must always be given a copy of this form after signing. In the following cases, minors have the right to release** **Information without a parent’s signature if: 1) Emancipated minors, 2) Minors receiving Substance Abuse Treatment** |

To/From; circle one.

Person/Agency Address Phone No. Fax

 **Primary Care Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 For the purpose of assessment, treatment planning, referral, and/or coordination of services.

Please **check** below indication which documentation regarding your treatment may be released or exchanged.

|  |
| --- |
| \_\_\_\_\_**Evaluation(s) (psychiatric, psychological, diagnostic reports) \_\_\_\_\_\_Medication History/Physicians Orders****\_\_\_\_\_Psychiatric Evaluation(s) \_\_\_\_\_\_Assessments(s) type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Service Note(s) dates:\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insurance Information****\_\_\_\_\_Transfer/Discharge Summary \_\_\_\_\_\_Educational/Social/ Developmental History** **\_\_\_\_\_Treatment Plan and Diagnosis \_\_\_\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Release of record is authorized for records containing substance abuse/use** **\_\_\_\_\_Release of record is authorized for records containing HIV/AIDS.****\_\_\_\_\_Periodic exchange of information between Eagle Psychosocial Rehabilitation Program and the noted agency.** |

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting

health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws,

however, may prohibit redisclosure. I understand that the information to be disclosed may include information regarding drug, abuse, and alcohol

abuse, HIV infection, AIDS or AIDs related conditions. When we disclose mental health and developmental disabilities information protected by

state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the

information that redisclosure is prohibited except as permitted or required by the laws.

I understand that I may revoke this authorization at any time unless this authorization is given as condition of obtaining insurance coverage and

the insurer has a legal right to contest the policy or claim under the policy. Such revocation does not affect the validity of the consent for

information disclosed/released prior to the revocation. In any event, if not revoked earlier this authorization expires automatically one year

(365 days) from signature date.

I understand that I may refuse to sign this authorization form. I understand that **Eagle Psychosocial Rehabilitation Program** willbegin and

continue client’s treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely,

voluntarily, and without coercion. I understand health insurance and information, indicated by initials, will be disclosed.

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Responsible Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement**

**requesting revocation signed and dated by the above name person or guardian**.

Consumer/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION**

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| **The cl The client must always be given a copy of this form after signing. In the following cases, minors have the right to release** **Information without a parent’s signature if: 1) Emancipated minors, 2) Minors receiving Substance Abuse Treatment** |

To/From; circle one.

Person/Agency Address Phone No. Fax

 **Medication Mangement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 For the purpose of assessment, treatment planning, referral, and/or coordination of services.

Please **check** below indication which documentation regarding your treatment may be released or exchanged.

|  |
| --- |
| \_\_\_\_\_**Evaluation(s) (psychiatric, psychological, diagnostic reports) \_\_\_\_\_\_Medication History/Physicians Orders****\_\_\_\_\_Psychiatric Evaluation(s) \_\_\_\_\_\_Assessments(s) type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Service Note(s) dates:\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insurance Information****\_\_\_\_\_Transfer/Discharge Summary \_\_\_\_\_\_Educational/Social/ Developmental History** **\_\_\_\_\_Treatment Plan and Diagnosis \_\_\_\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Release of record is authorized for records containing substance abuse/use** **\_\_\_\_\_Release of record is authorized for records containing HIV/AIDS.****\_\_\_\_\_Periodic exchange of information between Eagle Psychosocial Rehabilitation Program and the noted agency.** |

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting

health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws,

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abuse, HIV infection, AIDS or AIDs related conditions. When we disclose mental health and developmental disabilities information protected by

state law (G.S. 122C) or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the

information that redisclosure is prohibited except as permitted or required by the laws.

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the insurer has a legal right to contest the policy or claim under the policy. Such revocation does not affect the validity of the consent for

information disclosed/released prior to the revocation. In any event, if not revoked earlier this authorization expires automatically one year

(365 days) from signature date.

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Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Responsible Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Consumer/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **The client** notified **me verbally that he/she wishes to revoke this authorization with an effective date of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION**

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| **The cl The client must always be given a copy of this form after signing. In the following cases, minors have the right to release** **Information without a parent’s signature if: 1) Emancipated minors, 2) Minors receiving Substance Abuse Treatment** |

To/From; circle one.

Person/Agency Address Phone No. Fax

 **Wake County Human Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 For the purpose of assessment, treatment planning, referral, and/or coordination of services.

Please **check** below indication which documentation regarding your treatment may be released or exchanged.

|  |
| --- |
| \_\_\_\_\_**Evaluation(s) (psychiatric, psychological, diagnostic reports) \_\_\_\_\_\_Medication History/Physicians Orders****\_\_\_\_\_Psychiatric Evaluation(s) \_\_\_\_\_\_Assessments(s) type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Service Note(s) dates:\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insurance Information****\_\_\_\_\_Transfer/Discharge Summary \_\_\_\_\_\_Educational/Social/ Developmental History** **\_\_\_\_\_Treatment Plan and Diagnosis \_\_\_\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Release of record is authorized for records containing substance abuse/use** **\_\_\_\_\_Release of record is authorized for records containing HIV/AIDS.****\_\_\_\_\_Periodic exchange of information between Eagle Psychosocial Rehabilitation Program and the noted agency.** |

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Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Responsible Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement**

**requesting revocation signed and dated by the above name person or guardian**.

Consumer/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **The client** notified **me verbally that he/she wishes to revoke this authorization with an effective date of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION**

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To/From; circle one.

Person/Agency Address Phone No. Fax

 **Lisa Wachter, NCC, LCAS, LPC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 For the purpose of assessment, treatment planning, referral, and/or coordination of services.

Please **check** below indication which documentation regarding your treatment may be released or exchanged.

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| \_\_\_\_\_**Evaluation(s) (psychiatric, psychological, diagnostic reports) \_\_\_\_\_\_Medication History/Physicians Orders****\_\_\_\_\_Psychiatric Evaluation(s) \_\_\_\_\_\_Assessments(s) type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Service Note(s) dates:\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insurance Information****\_\_\_\_\_Transfer/Discharge Summary \_\_\_\_\_\_Educational/Social/ Developmental History** **\_\_\_\_\_Treatment Plan and Diagnosis \_\_\_\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Release of record is authorized for records containing substance abuse/use** **\_\_\_\_\_Release of record is authorized for records containing HIV/AIDS.****\_\_\_\_\_Periodic exchange of information between Eagle Psychosocial Rehabilitation Program and the noted agency.** |

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Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Responsible Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement**

**requesting revocation signed and dated by the above name person or guardian**.

Consumer/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **The client** notified **me verbally that he/she wishes to revoke this authorization with an effective date of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION**

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To/From; circle one.

Person/Agency Address Phone No. Fax

 **Dwan Kelsey NP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 For the purpose of assessment, treatment planning, referral, and/or coordination of services.

Please **check** below indication which documentation regarding your treatment may be released or exchanged.

|  |
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| \_\_\_\_\_**Evaluation(s) (psychiatric, psychological, diagnostic reports) \_\_\_\_\_\_Medication History/Physicians Orders****\_\_\_\_\_Psychiatric Evaluation(s) \_\_\_\_\_\_Assessments(s) type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Service Note(s) dates:\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insurance Information****\_\_\_\_\_Transfer/Discharge Summary \_\_\_\_\_\_Educational/Social/ Developmental History** **\_\_\_\_\_Treatment Plan and Diagnosis \_\_\_\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_Release of record is authorized for records containing substance abuse/use** **\_\_\_\_\_Release of record is authorized for records containing HIV/AIDS.****\_\_\_\_\_Periodic exchange of information between Eagle Psychosocial Rehabilitation Program and the noted agency.** |

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Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Responsible Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement**

**requesting revocation signed and dated by the above name person or guardian**.

Consumer/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION**

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To/From; circle one.

Person/Agency Address Phone No. Fax

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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(365 days) from signature date.

I understand that I may refuse to sign this authorization form. I understand that **Eagle Psychosocial Rehabilitation Program** willbegin and

continue client’s treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely,

voluntarily, and without coercion. I understand health insurance and information, indicated by initials, will be disclosed.

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legally Responsible Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement**

**requesting revocation signed and dated by the above name person or guardian**.

Consumer/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **The client** notified **me verbally that he/she wishes to revoke this authorization with an effective date of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Self Medication Acknowledge Form**

I acknowledge that I have received a copy of Eagle PSR Medication Policy. I understand that under no circumstances may Eagle PSR employee, dispense, or stock over-the counter medications to clients. I agree with this policy and consent that if I should need to self-administer medications at any time while receiving Eagle PSR services, I will provide Eagle PSR staff with a notice from a licensed medical doctor stating that I am capable and responsible for self-administering medications. I have been given an opportunity to read this policy and ask questions of the Eagle PSR staff. I also understand that if I should have any questions about the Medication Policy, I can contact Eagle PSR at (919) 896-6938.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Name** DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client’s Signature** (Parent or Guardian) DATE

Physician Recommendation/Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Physician Signature** DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Staff Member** DATE