North Carolina Department of Health and Human Services

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ Date of Birth_____

Client Medical Record #_____ Client SS # *(Optional)*_____

I _____ hereby authorize
(Client or Personal Representative)
_____ to disclose specific health information
(Name of Provider/Plan)
from the records of the above named client to: _____
(Recipient Name/Address/Phone/Fax)
_____

_____

for the specific purpose(s):_____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE: This Authorization was revoked on _____	_____
(Date)	*(Signature of Staff)*

DHHS-1000 (1/03)
Authorization to Disclose Health Information

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by_____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any action
(Date)

taken on this authorization prior to the rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Staff)	*(Date)*	*(Signature of Witness)*	*(Date)*

Date:_____

Dear Physician:

Your patient,_____ _____ (participant's name) is

___Interested in participating in our program

___Interested in continuing to participate in our program

In order to safely provide this service, our program requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions or contraindications to our program. Therefore, when completing this form, please note whether these conditions are present, and to what degree:

ORTHOPEDIC
Atlantoaxial instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

NEUROLOGIC
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

OTHER
Age - under 4 year
Indwelling Catheters
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

MEDICAL/PSYCHOLOGICAL
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Setting
Heart conditions
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought control disorders
Weight control disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in our program(s), please feel free to contact Hochoka Retreat Center at the address and phone number indicated below.

Sincerely,

Kimberly Clarke

HOCHOKA
Retreat Center
HEALING BY THE WAY OF THE HORSE

4211 Buff Street
Hickory, NC 28602
(704) 651-4800
www.healingwithhorses.com

Healing by the Way of the Horse

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: _____Date of Birth: _____ Height: _____Weight: _____
Address:_____
Diagnosis:_____
_____
Past/Prospective Surgeries:_____
Medications: _____
Seizure Type: _____ Controlled?: Yes No Date of last seizure:_____
Shunt present?: Yes No Date of last revision(s): _____ Date of last Tetanus Shot_____
Special Precuations/Needs:_____
_____
Mobility: Independent Ambulation? Yes No Assisted Ambulation? Yes No Wheelchair? Yes No
Braces/Assistive Devices:_____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Yes	**No**	**Coments**
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Hochoka Retreat Center Farm will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/ credentialed health professional (e.g. PT, OT, Speech language Pathologist, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: _____MD DO NP PA Other:_____
Signature: _____ Date:_____
Address: _____ City_____ State_____ Zip _____
Phone: (____)_____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION UNDER FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be subject to redisclosure and may no longer be protected by federal privacy regulations, including HIPAA. This includes any quotes or comments by any media, including but not limited to newspapers, photographers, etc. I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

Personnel Name:_____ ID/SS #: _____

Personnel Address: _____Date of Birth: ___/__ /_____

(Street/City/State/Zip)

Persons/organizations providing the information:_____

(Provider name)

Persons/organizations receiving the information: (Send to):

_____

_____

_____

Specific description of information, covering care from:_____to_____.

(Start Date) (End Date)

Complete health records and bills(prescription bills, history and physical, discharge summary, operative reports,

consultation reports, radiology and imaging reports), excluding all images (x-rays, photographs, etc.)

Other (please specify)_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____. Initials:_____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and that, if I do revoke this authorization, this will not have any affect on any action the providing organization takes before receiving the revocation. Initials:_____
3. I understand that I have the right to refuse to sign this Authorization. Initials:_____
4. I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law. Initials: _____
5. I understand the data release may include material protected by law including Mental Health, Drugs and Alcohol, HIV/AIDS and other communicable diseases and Genetic Testing. Initials:_____

I have read and understand the information in this Authorization.

_____ Date: _____

Signature of Personnel

(*Form MUST be completed before signing.)*