Newcastle Family Therapy, PLLC
5200 Park Road, Suite 104E
Charlotte, NC 28209

Client Information Form

Demographic Information:

Client's Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Responsible Party (if client is a minor):

Legal Guardian's Name: _____

Child Lives with: _____

Emergency Contact: _____

Emergency Contact phone number: _____

Insurance:

Insurance Company: _____

ID #: _____

Please Initial here: _____

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Professional Disclosure Statement

Thank you for choosing Newcastle Family Therapy, PLLC. Starting therapy is a major decision and you may have questions—feel free to ask and I will try my best to provide you with the information you need. This document is intended to inform you of my policies, state and federal laws, and some of your rights.

Professional Credentials

Laurie W. Howell, LMFT earned a Masters degree in Marriage and Family Therapy from Virginia Polytechnic and State University in 2001. Laurie is a Licensed Marriage and Family Therapist (#977) through the North Carolina Marriage and Family Therapy Licensure Board. My education and experience have prepared me to provide therapy to individuals, children, adolescents, groups, adults, couples, and families.

Informed Consent and Counseling Agreement

By reading and signing this document you are consenting to treatment with Laurie W. Howell, LMFT and acknowledging that you have been informed of your rights related to therapy.

Counseling Relationship

During the time we work together, we usually will meet weekly or bi-weekly (depending upon your needs) for 45-50 minute sessions. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contacts will be limited to our sessions together and necessary phone conversations. Please do not offer me gifts or ask me to engage in social activities with you (this includes social networking).

Social Networking Policy

As stated above, this relationship is a professional one and not a social one. With this in mind, I do not interact with patients or their family members online via social media sites such as Facebook, LinkedIn, YouTube, Instagram, Twitter, WordPress blogs, and/or Tumblr. Please be aware that I respect your privacy and will not search your private information online without your consent. There may be a time when social media issues are relevant to your treatment plan and goals, and in this case I would get your written consent to review this material.

Effects of Counseling Relationship

At any time, you may initiate with me a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing therapy. Although I expect you to benefit from therapy, I cannot guarantee any specific results. Therapy is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. You may feel distressed, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. Although the exact nature of changes resulting from therapy cannot be predicted, I intend to work with you to achieve the best possible results for you.

Record Keeping

Initial paperwork from today, my notes, any billing records, and any work shared and completed during therapy will become a part of your record. Your record is stored in a locked file cabinet.

Cost of services for self-pay clients

The cost of services is $130.00 per session. Payment is expected at the end of each session. Longer or shorter sessions are prorated from these basic fees. A receipt will be provided including all information necessary for insurance carriers and health savings accounts. Phone consultation may be billed as a session if the call exceeds 15 minutes. Written reports requested by clients will be completed at a rate of $50.00 per hour. The cost of services may be re-assessed annually. Cash, check, and credit (VISA/MasterCard) are acceptable methods of payment.
For more details about costs for self-pay clients, please also see the fee agreement.

Cost of services for insurance clients

Co-pays, when applicable, are due at the end of each session. You may be expected to pay for the session in full until your annual deductible is met. For more details about insurance costs, please also see the fee agreement.

Please Initial here: _____

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Overdue fees

Payment is expected at the time of the session. However, there are some cases when insurance may be filed prior to payment being expected. In the event that fees have not been paid in a timely manner, I will make reasonable attempts to contact you by phone and by postal service. If the balance has not been paid in a reasonable time frame, I reserve the right to use a collection agency or to inform you on my intentions to file with small claims court in Mecklenburg County. The cost of using these services would be added to your balance due.
For more details about overdue fees, please also consult the fee agreement.

Cancellation and No-show Fees

Please keep your scheduled appointments and arrive a few minutes prior to your scheduled appointment time. If you need to cancel an appointment, please provide 24-hours advance notice. If adequate notice is not provided, you may be charged a $100 cancellation/no show fee (unless we both agree that circumstances preventing you from attending were beyond your control). This fee must be paid in full prior to your next scheduled appointment.
For more details about these charges, please consult the fee agreement.

Client Initials: _____

Court

It is my policy not to testify in court unless subpoenaed. Fees for court appearances (including preparation and travel time) and court reports will be $250.00 per hour; a $500 retainer fee is due up front and will be applied to any incurred court costs. Court costs are generally not insurance reimbursable.

Confidentiality

Treatment is confidential. This means the client's name and any information about the client will not be discussed without the client and/or guardian's permission. The confidentiality of information you share with me is protected by law and by my professional ethics. **There are several exceptions to laws about privacy that are outlined in the Privacy Practices Notice**. Some of these exceptions include: **Suspected child abuse and/or neglect must be reported; action must be taken if it is determined a client is in danger to themselves or to others; and it is possible that client information/records will be released if ordered by a court**. In the event that I am ever unable to continue providing therapy, either temporarily or permanently; I have requested for my colleagues Trent Morrow, LCSW and/or Marlea Leary, LCSW to contact my clients and offer their services.
I provide the above-mentioned colleagues with a list of my clients' names and numbers.

Emergencies

You may call my office phone (which is also a cell phone number) and I will return your call as soon as I am able. There are times when I may be in session with other clients, but your call will be returned. Please do not hesitate to call 911 or the psychiatric emergency room at 704-358-2800 in the event of a life-threatening emergency.
In the event of an *extended leave of absence* during which I am out of town or unable to manage phone calls due to illness or personal emergency, my voicemail will indicate who current clients should call for assistance.

Contact and Communications/Electronic Communication Policy

Telephone contact: You may reach me by calling (704) 650-9425. Unfortunately, I will not always be available to answer your call. Please leave me a message and I will return your call as soon as possible. This is confidential voicemail.
Email contact: Please feel free to email me at laurie.howell@gmail.com. Please be aware that emails sent from this address are not encrypted. Please limit emails to appointment requests or cancellations. Email is not a substitute for seeing me. If you feel you need to be seen, please call and request an appointment. Email should NOT be used to communicate sensitive medical information such as diagnoses, testing results, or substance abuse information. Emails sent will become a part of your record; a copy will be printed and put in your chart.
Texts: Texts to your therapist, like emails, should be kept to appointment requests, appointment cancellations, or requests for a telephone call.

Please Initial here: _____

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Tele-health Policy

I understand that the service provided (hereafter referred to as tele-health sessions) is therapy delivered by secure audio and video communication via the internet. Tele-health sessions are generally used when a client is unable to attend in-office appointments because of location. I understand that Newcastle Family Therapy, PLLC only provides tele-health sessions to established clients who are deemed fit for tele-health sessions and are located in the state of North Carolina.

I understand that during tele-health sessions Newcastle Family Therapy, PLLC will need to securely collect and record personal information such as my address during the session. I agree to regularly update this information (contact information and address) as well as any emergency contacts. Failure to do so releases Newcastle Family Therapy PLLC from any and all ethical or legal obligation to warn of life-threatening situations.

I agree to assume full responsibility for confidentiality because unlike face-to-face therapy sessions the therapist is unable to control my physical location during the time of the tele-health session. During tele-health sessions the therapist will assure that no one is able to overhear my side of our conversation. The client is responsible for choosing a location where their privacy can be assured.

The nature of tele-health sessions involves some risk because my therapist cannot reasonably intervene in situations that may happen in crisis. As such, I agree to take full responsibility for 1) whether or not I initiate tele-health therapy, 2) what I will do in the case of emergency for emotional support, and 3) knowing how to contact local crisis or emergency services.

I agree to provide an emergency contact and my therapist (Newcastle Family Therapy PLLC) has permission to contact a doctor, family/friend, or appropriate authority in emergency situations. I understand that Newcastle Family Therapy PLLC will not provide tele-health sessions unless this form is completed in full and I understand that falsification of this information releases Newcastle Family Therapy PLLC from all legal responsibility and repercussions related to notifying the appropriate person(s) in the case of an emergency.

As during in-office therapy, tele-health may include certain situations in which disclosures made to me cannot be kept private due to professional ethics and the law. The following information describes these situations. 1. If you indicate that you are in serious and immediate risk of harming yourself or someone else. 2. If you indicate that you are involved or have knowledge of the abuse of a minor child, an elderly adult, or a disabled person. 3. If I am ordered to release information by subpoena due to a court proceeding. 4. If you indicate that you were sexually abused by another licensed mental health professional. Be assured that your right to confidentiality is very important to me. In the unlikely event that I must breach confidentiality I will make every effort to use care and discretion while meeting my legal and ethical obligations.

Tele-health Session Emergency Contact Information: (please complete if tele-health sessions are requested)

Name:
Relationship:
Telephone number:
Email address (if possible):

Grievances

If you are dissatisfied with any aspect of our work, please talk with me about it. If you think you have been treated unfairly or unethically, and we cannot resolve the problem, you may contact the North Carolina Marriage and Family Therapy Licensure Board, for clarification of clients' rights as I've explained them to you or to lodge a complaint.

Client's Rights:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, this provider is NOT required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

Please Initial here: _____

(For example, you may not want a family member to know that you are seeing this provider. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. This provider may deny your request. On your request, this provider will discuss with you the details of the amendment process.

Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, this provider will discuss with you the details of the accounting process.

Right to Treatment: You have a right to treatment, including access to medical care and habilitation, regardless of your age/degree of Mental Health/Developmental Disability/Substance Abuse disability. The treatment you receive will be age-appropriate and in the least restrictive environment.

You have the right to refuse treatment.

You have the right to privacy, humane care, and collaboration with therapist regarding goals.

You have the right to contact us to request a copy of your treatment plan.

You have the right to a paper copy of this notice.

Please sign below indicating you 1) have read and understand this counseling agreement and you consent to treatment and 2) you have read and understand your rights as a client.

I consent to mental health treatment provided by Newcastle Family Therapy PLLC. I understand and authorize Newcastle Family Therapy PLLC to release any and all records pertaining to my treatment to any applicable insurance company, primary care physician, psychiatrist, or referring professional. The release of any and all records may be done electronically or by email if such disclosure is necessary for claims processing, case management, coordination of care, or for utilization review purposes.

Client Name: _____Signature: _____ Date: _____

Legal Guardian: _____ Signature: _____ Date: _____

Therapist: Laurie W. Howell, LMFT Signature: _____ Date: _____

Please Initial here: _____

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Fee Agreement

I _____ agree to pay Newcastle Family Therapy, PLLC for professional services rendered by Laurie W. Howell, LMFT. Professionals services include, but are not limited to, individual and family sessions, assessments, report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals, preparation of records, preparation of treatment summaries, any other service you may request, or services that are deemed reasonable and necessary by the therapist.
I agree to pay Newcastle Family Therapy, PLLC according to the following fee schedule:

1) $130.00 for an intake assessment.
2) $130.00 per hour for individual and family sessions and other related professional services.
3) $130.00 per hour to participate in legal proceedings of any kind, this includes, but is not limited to, appearing in court as a witness, waiting in court, traveling, preparing reports, testifying, responding to emails, and any other related costs and expenses.
4) Or in the case of in-network insurance I agree to pay the remaining member's expense as stated in the explanation of benefits by my insurance company. It is my responsibility to understand my policy and therefore my financial obligation. Payment is due at the time the Remittance Advice is delivered by my insurance company.
5) There is a $5 dollar charge for a declined form of payment i.e. credit card, HSA, check etc.
6) I agree if my insurance policy is terminated I am responsible for the full rate of the charge.

I agree that fees are due at the beginning of each session. If I do not provide 24-hour notice prior to cancelling an appointment, I will be billed $100.00 for a missed appointment fee. If I do not show for an appointment I will be billed $100.00 for a no show fee. I agree that if I miss two (2) or more appointments my case may be terminated at the discretion of this therapist.

I agree that all fees, costs and expenses are due 30 days after an invoice for services is presented to me and that any balance owed beyond 30 days, will incur a late fee and interest rate equal to 2.5% of any outstanding balance.
Newcastle Family Therapy, PLLC will file an insurance claim for any fees incurred except those relating to participating in legal proceedings or professional services not typically covered by any form of insurance. I understand that if any form of insurance, for any reason whatsoever, does not pay the invoiced cost for the professional services rendered, I will be personally responsible to pay whatever balance is owed.
I agree that Newcastle Family Therapy, PLLC may use and disclose medical information about me so that the services received may be billed and payment may be collected.
I further also agree, that if Newcastle Family Therapy, PLLC must acquire the services of an attorney to collect any outstanding balance on my account, I will be responsible for paying the actual costs in filing any legal action, any out of pocket expenses relating to the filing of a legal action and attorney fees equal to fifteen percent (15%) of any outstanding balance.

Date: _____

Signature: _____

Printed Full Name: _____

Please Initial here: _____

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5200 Park Road, Suite 104E
Charlotte, NC 28209

Credit Card Authorization Form

I, _____ authorize Newcastle Family Therapy, PLLC to keep my signature on file and charge my credit card for services rendered and late cancellation or no show fees when applicable.

This authorization is effective unless I provide written notification of a desire to cancel.

The credit card number listed below will be stored electronically in a password protected accounting program and this written copy will be blacked out for security purposes.

Client Name: _____

Cardholder' Name: _____

Billing Address: _____

Zip Code: _____

Credit Card Number: _____

Expiration Date: ____/_____

Cardholder's Signature: _____

Date: _____

Please Initial here: _____

Newcastle Family Therapy, PLLC
5200 Park Road, Suite 104E
Charlotte, NC 28209

Newcastle Family Therapy, PLLC
Laurie W. Howell, LMFT
5200 Park Road
Suite 104E
Charlotte, NC 28209
(704) 650-9425

HIPAA NOTICE OF PRIVACY PRACTICES

Effective April 13, 2013
Modified August 16, 2016

I. THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside of my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.
Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you may view a copy of it on my website which is located at www.newcastlefamilytherapy.com.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Not Requiring Your Prior Written Consent

This practitioner may use and disclose your protected health information (PHI), for treatment, payment, and health care operations purposes without your consent in the following ways:
Treatment: This practitioner may use and share PHI with others to provide and coordinate your healthcare treatment. An example of treatment is when this practitioner consults with another health care professional such as your family practitioner or another therapist.

Please Initial here: _____

To Obtain Payment for Treatment: This practitioner may use and share PHI with others (health plans, insurance companies) to bill and collect payment for services provided to you.
Healthcare operations: This practitioner may use and disclose PHI with others in order to make improvements to services in business-related matters such as audits.
Reminders: This practitioner may use and disclose PHI to remind you about an appointment you have with this practitioner.
Business Associates: This practitioner may use and disclose PHI to provide some services through other businesses we call business associates in order for them to do the job we ask them to do (appointment reminder systems). When we do this we require the business associate to keep health information about you private.
Other disclosures: Your consent isn't required if you need emergency treatment provided. In the event that I try and get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think you would consent to such treatment if you could, I may disclose your PHI.

B. Uses and Disclosures Requiring Authorization

This practitioner may use or disclose PHI for purposes of outside treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when this practitioner is asked for information outside of treatment, payment and health care operations, this practitioner will obtain an authorization from you before releasing this information. This practitioner will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" refers to notes this practitioner may have made about conversations during a private, group, joint, or family counseling session, which this clinician may have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) This provider has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

C. Certain Other Uses and Disclosures Requiring Neither Consent nor Authorization

Your PHI may be used or disclosed without your consent or authorization for the following reasons:
Abuse: If this provider has reason to suspect that a child is abused or neglected, this provider is required by law to report the matter immediately to the North Carolina Department of Social Services.
Adult and Domestic Abuse: If this provider has reason to suspect that an adult is abused, neglected, or exploited, this provider is required by law to immediately make a report and provide relevant information to the North Carolina Department of Welfare or Social Services.

Health Oversight: The North Carolina Marriage and Family Therapy Licensure Board has the power, when necessary, to subpoena relevant records should this provider be the focus of an inquiry.
Judicial or Administrative Proceedings: Confidential information may be disclosed if a court issues a compelling disclosure; for the purposes of filing a petition for involuntary commitment; if an individual is a defendant in a criminal case and a mental examination has been ordered; for the purposes of complying with Article 3 of 7B of the General Statutes and Article 6 or Chapter 108A of the General statutes, or as required by other state or federal law.
Care and Treatment: Any treatment provider may share confidential information with another provider when necessary to coordinate effective care, treatment or habilitation; a responsible professional may share confidential information with a physician or other health care provider who is providing emergency services to the client; if there is reason to believe that the client is eligible for financial benefits through a government agency a facility may disclose confidential information to State, local, or federal government agencies; if there is reason to believe the client is eligible for educational services through a government agency;
Serious Threat to Health or Safety: If this provider is engaged in her professional duties and you communicate to her a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and this provider believes you have the intent and ability to carry out that threat immediately or imminently, this provider must take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 19; or (2) notifying a law enforcement officer.
Worker's Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
Research and planning: Public or private agencies may use confidential information for the purposes of research and evaluation in the areas of mental health, developmental disabilities, and substance abuse.
If disclosure is otherwise specifically required by law

IV. PATIENT'S RIGHTS

These are your rights with respect to your PHI:

The Right to Request Limits on Uses and Disclosures of your PHI*:* You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.
The Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing this provider. Upon your request, I will send your bills to another address.)
The Right to Inspect and Copy your PHI*:* You have the right to inspect or obtain a copy (or both) of your PHI used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may

have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

The Right to Amend*:* If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is a) correct and complete, b) forbidden to be disclosed, c) not part of my records, or d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) in your PHI.

The Right to an Accounting of Disclosures*:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, this provider will discuss with you the details of the accounting process.

The Right to a Paper Copy of this Notice.

V. COMPLAINTS

If you are concerned that this provider has violated your privacy rights, or if you disagree with a decision made about the access to your PHI, a direct conversation is welcomed and assurances are made that no retaliation will be made.

You may also send a written complaint to the secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue S.W. Washington, DC 20201.

You may also make a complaint to the North Carolina Licensed Marriage and Family Therapy Board/North Carolina Association of Marriage and Family Therapy (NCAMFT).

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint please contact me, Laurie W. Howell, LMFT at laurie.howell@gmail.com or 704.650.9425.

VII. NOTIFICATION OF BREACHES

In the case of a breach, Laurie W. Howell, LMFT is required to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, Laurie W. Howell, LMFT is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, Office for Civil Rights (Health and Human Services) must be notified in accordance with instructions posted on their website. Laurie W. Howell, LMFT bears the ultimate burden of proof to

demonstrate that all notifications were given or that impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation related to a risk assessment.

VIII. PHI AFTER DEATH

Laurie W. Howell, LMFT may disclose deceased individuals PHI to non-family members, as well as to family members, who were involved in the care or payment for healthcare of the patient prior to death. The disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preferences of the deceased individual.

IX. INDIVIDUALS' RIGHT TO RESTRICT DISCLOSURES: RIGHT OF ACCESS

Laurie W. Howell, LMFT is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full.
Laurie W. Howell, LMFT must provide you, the patient, a copy of PHI if you request it in electronic form. The electronic format must be provided to you if it is readily producible.
Laurie W. Howell, LMFT must provide you only with an electronic copy of your PHI, not direct access to electronic health record systems.
Laurie W. Howell, LMFT may, upon your request, transmit an electronic copy of PHI to an entity or person designated by you.
Laurie W. Howell, LMFT may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any).

My signature below indicates that I have reviewed and understand the above document and I am acknowledging that I have a copy for my records.

_____ _____

Signature of client or parent/guardian Date

Please Initial here: _____

Newcastle Family Therapy, PLLC
5200 Park Road, Suite 104E
Charlotte, NC 28209

Authorization to Disclose Health Information

Client Name_____

Date of Birth_____

Address _____

I hereby authorize Newcastle Family Therapy PLLC to disclose specific health information:
Release Information From:
Newcastle Family Therapy, PLLC
5200 Park Road, Suite 104E
Charlotte, NC 28209
Phone: 704-650-9425 Fax: 704-727-8145

Release Information To:

Name: _____

Address: _____

Purpose of Release: ☐ Ongoing Communication ☐ Legal purposes ☐Continued patient care

Dates of release: From _____ To_____

Information to be released: ☐Entire Record (not including psychotherapy notes) ☐Assessment ☐Attendance Dates

☐Other, please specify: _____

Patient's rights- I understand that:
I can cancel this authorization at any time. I must cancel in writing and send or deliver cancellation to the releasing party or practice named above. Any cancellation will apply only to information not yet released by either party.
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, this recipient may not re-disclose this information without my further written authorization unless otherwise provided for by state or federal law.
This is a full release including information related to behavioral/mental health, drug or alcohol treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
Newcastle Family Therapy, PLLC will not share or use my health information without my permission other than ways listed in the Notice of Privacy Practices.
Refusing to sign this form will not prevent my ability to get treatment.
I may request a copy of this signed authorization.

Signature of Client: _____Print: _____ Date: _____

Signature of Personal Representative: _____ Print: _____ Date: _____

Signature of Witness: _____Print: _____ Date: _____

Please Initial here: _____