The Arc
Northern Chesapeake Region

Achieve with us.

The Arc NCR Consent for Services Form

Name: _____
Date of Birth: _____
Date of Entry: _____

I, _____, hereby grant permission for The Arc Northern Chesapeake Region to obtain / release relevant oral and written information regarding myself / to schools, therapists, doctors, dentists, and any other persons or agencies involved in my care. I realize that any material released is solely for the purpose of understanding how to support me best while receiving services with The Arc Northern Chesapeake Region, and during a transition period of not more than 90 days after discharge. All information will be disclosed by my provider agency in accordance to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I also hereby consent for The Arc Northern Chesapeake Region to act for the following purposes on my behalf while in services with the agency:

(Check all that apply and initial to confirm authorization)

- ☐ Medical/dental services: to obtain and consent to medical and dental services on my behalf.
- ☐ Psychological and Psychiatric Treatment: to obtain records and information regarding any of my counseling, psychological, and psychiatric services and treatment (evaluations, assessments, individual and family therapy, etc.), but NOT including consent to psychotropic medication or psychiatric hospitalization.
- ☐ Social History
- ☐ Vocational Evaluations
- ☐ Arrange for and consent to out-of-state travel on my behalf.
- ☐ Other (specify)_____

I understand that I can revoke the above authorization at any time by a written statement. If I do not do so, these authorizations will be deemed to remain in effect for the duration of my services with The Arc Northern Chesapeake Region.

By signing below, I also indicate that I have been offered notice with this consent about said program's uses and disclosures of information. I understand that I have the right to request reasonable restrictions on the uses and disclosures of consented information. In accordance with HIPAA Section 164.506, I understand that protected health information created or received in the following situations is exempt from consent requirements: 1) emergency treatment, 2) where said provider is required by law to act, and 3) where there are substantial barriers to communication with my legal guardian, in the exercise of professional judgment, the said provider clearly infers from the circumstances they have my consent or said legal guardian's consent to receive treatment.

Signature: _____ Print Name: _____

Date: _____ Agency/ Relationship: _____

Witness: _____