Spotlight Social Skills

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AUTHORIZATION: USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name:_____ Date of Birth:_____
I hereby authorize Regina Feinberg to use or disclose my protected health information related to my condition for the purpose of coordinated care.

The information is to be disclosed to or obtained from:

Name:_____Phone#:_____ Fax#:_____

Information to be released: Current concerns, progress, diagnoses and patient history.

I understand that this health information may include HIV related information and/or information relating to substance abuse and that by signing the form, I am specifically authorizing the release of information relating to:
° Substance Abuse (including alcohol/drug abuse)
° HIV related information (including AIDS related testing)
The confidentiality of this record is required under Title 42 of the United States Code. This information cannot be released without my authorization as provided in this law.

X_____ _____
Signature of Client or Parent/Legal Guardian Date

1. I understand that the intent for release of this information is to coordinate care and maintain continuity of care with the practitioner, organization, or persons identified above.
2. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.
3. This authorization is valid for no more than one year from the date of signature unless I have indicated a date sooner than that here_____, and may be rescinded by my written notification to the address above at any time. Any use or disclosure already made with your permission cannot be undone.
4. I understand that my health care will not be affected if I do not sign this form.

I have read this authorization and understand it.

Date: _____ Signature: _____
Client or Parent/Legal Guardian