Beth L. Fineberg, Ph.D.
450 Wellington Rd
Indianapolis, IN 46260 Phone 317-872-4158

AUTHORIZATION TO RELEASE PROTECTED HEATH INFORMATION

Client_____ Date of Birth_____
Address_____

To facilitate diagnosis & treatment of the client, Dr. Fineberg is authorized to exchange information by mail, telephone and in-person conversations, and electronically by fax with:
Name/Organization_____
Address_____
Phone Number_____ Fax Number_____

Information to be released: Drug & Alcohol_____ (Initials) HIV-related_____(Initials)
Any or All of the following:

____Assessment Reports/Observations/Test Data
____Diagnosis/Prognosis
____Treatment Plans/Goals
____Dates & Course of Treatment
____Treatment Compliance
____Progress Notes
____ Admission/Discharge Summaries
____Presenting Complaints/Significant Issues
____Response to Treatment
____Attendance/Payment
____Treatment Suggestions/Recommendations
____Academic Records/Observations

Or Dr. Fineberg is permitted to testify in any legal proceeding regarding the client's treatment____

I understand that:

1) I may refuse to sign this Authorization and if I do so, Dr. Fineberg will not condition treatment, payment, or eligibility for benefits on my signing this Authorization.
2) I have the right to revoke this Authorization, except as action has already been taken in reliance upon it, by sending a written letter of revocation to Dr. Fineberg at the above address. If I do not revoke the Authorization, it will automatically expire 180 days from the signature date, unless a different expiration date or condition is specified here_____.
3) My Protected Health Information disclosed under this Authorization may be subject to redisclosure by the recipient and its privacy will no longer be protected by Law.
4) In consideration of this consent, I hereby release Dr. Fineberg from any and all liability arising therefrom.
5) This authorization is in compliance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, Public Law 104-191.
6) I agree that a photocopy of this form is acceptable.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the disclosure of my Protected Health Information in accordance with its terms.

Signatures: Client_____ Printed_____ Date_____
Witness_____ Date_____
Authorized Representative_____ Printed_____
Description of Authority to sign for the client _____ Date_____

Notice to Recipient of Information

This authorization is in compliance with Federal Regulation 42 CFR Part 2, which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted.