65 RAMAPO VALLEY ROAD STE 102 MAHWAH, NJ 07430
(973) 530-4155 PHONE (973) 273-4797 FAX

NOTICE OF PRIVACY PRACTICES

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about health care we provide to you or payment for health care provided to you. It may also be information about your past, present, or future medical condition. We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice. We may change the terms of this notice in the future. We reserve the right to make changes and to make the new notice effective for all medical information that we maintain. If we make changes to the notice, we will inform you. We may disclose medical information about you in the following circumstances: for payment, treatment or healthcare operations. We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition. We will use and disclose medical information about you whenever we are required by law to do so. You may request a comprehensive list of the instances and agencies we are required to disclose your medical information to. Other than the uses and disclosures described above we will not use or disclose medical information about you without the “authorization” – or signed permission – of you or your personal representative.

AUTHORIZATON FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS

I authorize the use/disclosure of health information about:

Individual's Name:____

Date of Birth:____

1. Person(s) authorized to use, disclose or receive information, include legal guardian, if applicable:

Primary Contact:	**Alternate Contact:**
Name:__________________ Address:_____________________________ ________________ Phone:_______________________________ ______ Relationship:__	Name:_______________________________ Address:______________________________ _____________________________________ Phone:_______________________________ Alt Phone:____________________________ Relationship:_________________________
Other Contact: Name:_______________________________ Address:_____________________________ _____________________________________ Phone:_______________________________ Alt Phone:____________________________ Relationship:_________________________	Other Contact: Name:_______________________________ Address:______________________________ _____________________________________ Phone:_______________________________ Alt Phone:____________________________ Relationship:_________________________

Attach additional sheets if needed.

2. I am authorizing **Spectrum Care Management and Counseling, LLC** to contact the primary contact or alternate contact, via telephone, to advise of any illness, injury or incident that may need prompt attention or authorization.

3. I am authorizing **Spectrum Care Management and Counseling, LLC** to provide the minimum necessary health information to the individuals listed above and/or other individuals who are permitted to visit.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect ability to obtain treatment or payment or my eligibility for benefits or services. I may inspect or copy any written information used/disclosed under this authorization.

5. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the DDD Privacy Officer. The revocation will be effective on the date that the Privacy Officer receives the request.

7. This authorization expires on ___________ or one year from the date of the individual's/legal guardian's signature.

8. A completed copy of this form will be maintained in the client record.

9. To Legal Guardians: If the individual receiving services is over the age of 18 and you have indicated that you are the Legal Guardian for this individual, you must provide copy of the Appointment of Guardianship to the Support Coordination Agency.

Signature (or mark*) of
Individual or Legal Guardian:____

Date of Signature: ____

Name of Legal Guardian* (if applicable):______________________________________
*Copy of Valid Appointment of Guardianship must be attached.

If Mark is provided in place of signature, the mark must be witnessed:

Witness Signature (if applicable): N/A

Witness Name/Title: N/A

C: Electronic Record – I Record
Residential Program (if applicable)
Day Program (if applicable)