EXPERIENCED SUPPORT COORDINATION

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:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Alt Phone:_____	Alt Phone:_____
Relationship:_____	Relationship:_____
Other Contact:	Other Contact:
Name:_____	Name: Experienced Support Coordination
Address:_____	Address:4660 Nottingham Way, Bldg. 4
_____	Hamilton, NJ 08690
Phone:_____	Phone: 609-245-8058
Alt Phone:_____	Alt Phone:_____
Relationship:_____	Relationship: Support Coordination agency

Attach additional sheets if needed.

2. I am authorizing **Experienced Support Coordination** 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 **Experienced Support Coordination** 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 a 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):_____

Witness Name/Title:_____

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