Rebecca J. Kincaid
2709-B Pinedale Dr.
Greensboro, NC. 27408

Phone: (336) 288-9900 **bjkincaid@gmail.com** **Fax: (336) 288-3177**

HIPAA AUTHORIZATION FOR USE & DISCLOSURE

I, _____, authorize Rebecca J. Kincaid M.S. LPA to disclose to and/or obtain from, _____ the following information:

Client Name:_____ **Record #:**_____

Description of Information to be Disclosed
(Patient/Client should check each item to be disclosed.)

____	Assessment	____	Social, Developmental, Medical History
____	Diagnosis	____	Educational Information
____	Psychosocial Evaluation	____	Discharge Summary
____	Psychological Evaluation	____	Financial/Reimbursements
____	Treatment Plan or Summary	____	Substance Abuse/Treatment
____	Service Notes	____	HIV/AIDS Information
___	Testing Information	____	Other:_____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. _____(initial)

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Rebecca J. Kincaid at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires one year past termination of treatment or one year past date of signature.

Conditions
I further understand that Rebecca J. Kincaid will not condition my treatment on whether I give authorization for the requested disclosure.

Redisclosure
Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not be prohibit the recipient from redisclosing it. Other laws however may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S 122C), substance abuse treatment information protected by federal law (42 C.F.R. Part 2) we must inform the recipient of the information that disclosure is permitted or required by these laws.

I will be given a copy of this authorization for my records if requested.

_____

Signature of Client, Parent or legal guardian if minor child Date