The Present Center for Mindfulness and Healing LLC

2607 North Harrison Street Wilmington DE 19802	www.presentcenter.net 267-254-2111	2 Cub Lake Road Byram Township, NJ 07821

We welcome you!

Please Tell Us A Little About You…..

Current Legal Name: ____

Preferred Name:____

Your Date of Birth:____

Gender: ______________________ Preferred Pronouns:______________

Address: ______________________ Home Phone:______________

______________________ Work Phone: ______________

______________________ Cell Phone:_ ______________

______________________ Email:______________

How do you Prefer to be Contacted: Home Work Cell E-mail

May our office call and leave a message for you at:

Home: Yes or No
Work: Yes or No
Cell: Yes or No

May our office contact you at the email address above? Yes or No

Special instructions about leaving messages: ______________________________

____

Who may we contact in case of an emergency?

Name: ______________________ Home Phone:______________

Address: ______________________ Work Phone: ______________

______________________ Cell Phone:_ ______________

______________________ Email:______________

What is your emergency contact's relationship to you? ______________________

Who may we thank for referring you? ______________________________

Health Insurance Information

If you are not using insurance it's ok to skip to the next section.

Name of Insured ________________________ Insurance Company __________________________

Member ID _____________________________ Phone (on Back of Card) _____________________

Group Number _________________________ Employer _____________________________________

Person Responsible for the Bill (if other than self):

Name ______________________________ Home Phone _______________________________

Address ____________________________ Work Phone ________________________________

____________________________ Cell Phone _______________________________

____________________________ Email: _____________________________________

Date of Birth ______________________________

What is the Relationship of the Above Payor to You?_____________________________________

☐ I understand that I am responsible for the payment of my bill in full. If I plan to submit my expenses to insurance, I can request a receipt with the required information.

☐ I also understand that a minimum of 24 hour notice must be given to cancel an appointment or I may be charged a fee of $75.00 for the missed session.

Signature ____ Date _______________________

Jenna Tedesco, Psy.D.
The Present Center for Mindfulness and Healing LLC

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HIPAA Notice Form

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGIST AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. **Uses and Disclosures for Treatment, Payment and Health Care Operations**
   I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here and some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - "Health Care Operations" are activities that relate to the performance and operations of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office, practice, group, etc. such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, practice, group, etc. such as releasing, transferring or providing access to information about you to other parties.

2. **Uses and Disclosures Requiring Authorization**

   I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a great degree of protection than PHI.

   You may revoke all such authorizations of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization: or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

3. **Uses and Disclosures with Neither Consent Nor authorization**
   I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable causes, on the basis of my professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity. I am required by law to report this to the Department of Public Welfare.
- **Adult and Domestic Abuse:** If I have a reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services I provides you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out that threat, I must take a reasonable measure to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

4. Patient's Rights and Psychologist's Duties and Patient Rights:

- **Right to Request Restrictions:** You have the right to request restriction on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section 3 of this Notice). On your request, I will discuss with you the details of the accounting process.
- **Right to Paper Copy:** You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

5. Psychologists Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. If I revise my policies and procedure, I will notify you by mail. I reserve the right to change the privacy policies described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

6. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to you records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

7. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2016. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

Signature: ____ Date: ______________________________

PRESENT CENTER for MINDFULNESS AND HEALING, LLC
Jenna Tedesco, Psy.D.

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Billing Responsibility Agreement

I understand that I am ultimately responsible for all charges. In the event a third-party payer (such as my health insurance plan) does not pay my therapist for any billed sessions or other fees, I accept responsibility for paying those fees.

I understand that appointments reflect professional time set aside by my therapist for me and will do my best to make all scheduled appointments or to cancel them with at least 24 hours notice.

I accept responsibility for paying a **$75.00 fee** for each appointment broken without at least **24 hours notice**.

Schedule Of Fees

Amount	***Service Provided***
$150.00 per Hour	Session Time
$300.00 per Hour	Any and all documentation preparation and compilation for court.
$3000.00 per Day	One day in court. Must be paid in full by day of appearance.
$150.00 per Hour with 15 Minute Minimum	Any contact with providers, agencies, schools, etc.
$300.00 per Hour	Court consultation via telephone. One hour minimum billed.
$150 per Hour	All services related to psychological testing ***not*** covered by insurance. Including scoring and report compilation.

______________________________________ ________________

______________________________________ ________________

Patient, parent, or legal guardian signature Date

______________________________________ ________________

Witness Date

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Credit Card on File Agreement

Thank you for choosing The Present Center for Mindfulness and Healing LLC. We ask that all patients keep an active credit card on file; this may be used to pay for copays, deductibles, and other out-of-pocket expenses including $75.00 missed session fees when applicable. Your card will be charged after each billable incident. If your card is declined or otherwise no longer active, we ask that you replace it promptly. Feel free to speak with your therapist about any concerns which may arise.

Please provide the following information (please print if possible):

Patient Name:____
Patient Address:____
____
____

Person Responsible/Name on Card:___________________________________
Card Number:____
Expiration Date:____
Security Codes on Back of Card:_____________________________________

By signing below, you authorize The Present Center for Mindfulness and Healing LLC to bill the above card for services as outlined above. You may revoke this signature and the authority it confers at any time in writing. Thank you for choosing The Present Center for Mindfulness and Healing LLC.

Signature:____
Date:____

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Psychological Assessment

Basic Information			
Legal Name			
How would you like to be addressed?			
Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Email address			
How would you prefer we contact you?			
Date of Birth		Gender and Preferred Pronouns	
Occupation		Employer	
Primary Language:			
Handedness:		Referred by:	
Relationship Status: __Single __Partnered __Married __Separated __Divorced __ It's Complicated			
Ethnic Identification (select as many as apply): □ European-American □ African-American □ Asian-American □ Latino/a □ Native-American □ Other:____			

Why are you completing this paperwork?

Religion/Spiritual practices:

What religious beliefs were you raised with?

What are your current religious/spiritual beliefs?

How often do you attend religious services?

Marital Status and History:

Name of partner	Married or partnered?	Years of relationship	Relationship ended because…(divorce, separation, death)	If applicable, circumstances around partner's death

Presently, are you

☐ Single ☐ Married ☐ Widowed ☐Divorced ☐ In a relationship
☐Living with partner ☐ It's complicated

How long have you been in your current relationship?

How would you describe your current relationship?

Have you ever been in a relationship in which you experienced domestic violence (hitting, beating, belittling, shaming in front of others, overly controlling and restrictiveness, etc)? If so, please describe.
Who resides in your home currently?
Besides your own children, who else are your raising or have you raised?

Names, ages, and parentage of your children:

Name of Child	Date of	Child's Other	Who helps you	What kind of

Names, ages of grandchildren.

Name of Grandchild's Parent	Name of Grandchild	Approx age/DOB	Quality of relationship you have with grandchild

Early History

Important people in your life

Where were your parents born?

Where were your grandparents born?

How often did you move around as a child?

Who raised you? Were you ever raised by people other than your parents, and if so, by whom? How come?

Parent	Name	DOB	DOD and circumstances of their passing	Quality of relationship	Physical or mental health issues
Mother					
Father					
Stepmother					
Stepfather					
Paternal grandmother					
Paternal grandfather					
Maternal grandfather					
Maternal grandmother					
Other important figure					
Other important figure					
Other important figure					
Other important figure					
Other important figure					
Other important figure					

Parents

Year parents married/became partnered:

Year parents divorced/separated:

Parent	Name	Occupation	Level of Education	Quality of relationship	Physical or mental health issues
Mother					
Father					
Stepmother					
Stepfather					
Paternal grandmother					
Paternal grandfather					

Maternal grandfather					
Maternal grandmother					
Other important figure					
Other important figure					
Other important figure					

Were you abused or neglected as a child?						
	Name	Physical abuse	Sexual abuse	Emotional abuse	Neglect	Other
Mother						
Father						
Stepmother						
Stepfather						
Paternal grandmother						
Paternal grandfather						
Maternal grandfather						
Maternal grandmother						
Other important figure						
Brother						
Sister						
Aunt						
Uncle						
Foster care acquaintance						
Teacher						
Priest/religious figure						

Were any of your siblings abused?____

Did you witness any abuse perpetrated on others as a child?___________________________________

Describe the ways your family disciplined you, and the ways they reinforced/rewarded good behaviors____

Siblings					
	Name	DOB	DOD and circumstances of passing	Occupation	Quality of relationship
Brother					
Brother					
Stepbrother					
Sister					
Sister					
Stepsister					

Do any of your relatives suffer from mental health issues or addictions, including gambling disorder?____

Are you aware of any complications in your birth, or during gestation?
____
____

How old were you when you took your first steps? ____

Were there any delays or other challenges with walking?____________________________

How old were you when you said your first words?
____
____

Were there any delays or other challenges with speech and language?______________

Education			
School Type	Name of School	Years Attended	Graduated/degree?
Elementary			
Elementary			
Elementary			
Middle			
Juniior High			
High school			
High school			
College			
College			
Vocational college			
Vocational college			
Graduate school			
Graduate school			
Post-graduate			
Other			

Did you have any difficulty learning to read, to do math, or any other academic task?____

Were you repeated or did you skip a grade?____

Did you enjoy school as a youngster? Why or why not?

____

____

Work History				
Job Title/Description	Company	Years	Left because…	Other

What was the best job you ever had, and why?

What was the worst job you ever had, and why?

What job did you always wish you had?

Military Service					
Branch	Dates of Service	MOS	Rank	Were you injured in service	Nature of Discharge

Were you deployed?

Dates of deployment	Place of deployment	Active combat?	Trauma?

Did you experience Military Sexual Trauma (MST) in the service? ______________________________

Did you experience racism in the service? ____

Did you experience sexism in the service? ____

Were you exposed to burn pits or other chemical exposures in the service? ___________________

Did you receive the anthrax series vaccines before deployment? ____________________________

Did you enlist or were you drafted? ____

MEDICAL INFORMATION

Primary Care Provider:	
Name of Provider	Type of Health Care Practice
Address	
Email/Website Address	
Phone	Fax

Additional Health Care Provider 1	
Name of Provider	Type of Health Care Practice
Which Conditions are Treated By this Provider?	
Address	
Email/Website Address	
Phone	Fax

Additional Health Care Provider 2	
Name of Provider	Type of Health Care Practice

Which Conditions are Treated By this Provider?	
Address	
Email/Website Address	
Phone	Fax

Additional Health Care Provider 3	
Name of Provider	Type of Health Care Practice
Which Conditions are Treated By this Provider?	
Address	
Email/Website Address	
Phone	Fax

Current Height_______________ Current Weight_______________

What do you wish your weight to be?____________________

Have you used tobacco? □ Yes □ No

When was your last use? ______________________________________

If you use habitually, how much do you use?_________________

Do you use nutrasweet/aspartame?_□ Yes □ No

Have you had trouble with gambling or recreational spending?

□ Yes □ No

Do you have trouble with other addictions/compulsions? □ Yes □ No

Health in Family: Please indicate if you or someone in your family has suffered from any of the following health care concerns:

Illness/condition	You		Others in Your Family		
	Current	Past	Mother	Father	Other relative
Physical Health Concerns					
General					
Headaches					
Pain					
Glasses/contacts/visual impairment					
Hearing impairment					
Sleep disturbances					
Fatigue					
Ear infections					
Sinus issues					
Skin Conditions					
Rashes					
Athletes foot					
Other fungus					
Warts/skin tags					
Ringworm					
Psoriasis					
Lice					
Scabies					
Cancer					
Sunburn					
Eczema					
Dry skin					
Oily skin					
Acne (adolescent, adult)					
Other					

Allergies					
Scents, oils, lotions, etc					
Detergents					
Foods					
Additives					
Medications					
Latex					
Animal fur/dander					
Other					
Muscles/joints					
Rheumatoid arthrtitis					
Psoriatic arthritis					
Osteoarthritis					
Broken bones					
Dislocated bones					
Scoliosis					
Problem disks					
Subluxations					
Fusions					
Lupus					
TMJ/jaw pain					
Cramps					
Weak or sore muscles					
Bursitis/ stiff or painful joints					
Tendonitis					
Lower back pain					
Other back pain					
Hip pain					
Neck pain					
Fibromyalgia/myalgia					
Other					
Nervous System/Brain					
Epilepsy					
Seizures					
Alzheimer’s dementia					
Frontotemporal dementia					
Dementia but unknown what kind					
Head injuries					
Loss of consciousness					
Concussions					
Dizziness					
Ringing in ears					
Numbness/tingling					
Sciatica					

Tumors					
Multiple Sclerosis					
Learning difficulties					
Cognitive impairment					
Other					
Circulatory/heart					
Aneurism					
Rheumatic fever					
Heart valve issue					
Varicose veins					
Red, flush skin					
Irregular heartbeat					
A-fib					
Rapid heartbeat					
Blood clotting/DVT					
Fingertips turn blue					
Swollen ankles					
Embolism					
Stroke					
Heart attacks					
Heart disease					
High blood pressure					
Low blood pressure					
Reynauds					
High cholesterol					
High triglicerides					
Cold all the time					
Other					
Respiratory					
Asthma					
COPD					
Emphysema					
Fainting					
Shortness of breath					
Other					
Digestive/urinary					
Eating disorder					
Irritable bowel disease					
Crohn's Disease					
Feel sleepy after meals					
Chronic diarrhea					
Gallbladder pain/attacks					
Pain between shoulder blades					
Bad breath					
Urinary tract infections					

Sweat has strong odor					
Bowel resections					
Gas/belching within an hour of eating					
Colitis					
Ulcerative colitis					
Kidney disease/issue					
Heartburn/acid reflux					
Other					
Women's Health					
Endometriosis					
Cysts					
Yeast infections					
Premenstrual Dysphoria					
Reproductive cancers					
Infertility					
Irregular menstruation					
Hysterectomy					
Pregancies to term					
Pregnancy losses					
Abortions					
Other					
Other Conditions					
Diabetes I					
Diabetes II					
Fibrotic tumors					
Hyperthyroid					
Hypothermia					
Hypothyroid					
Irritable bowel disease					
Kidney disease					
Hepatitis (A,B,C)					
Polio					
Lyme disease					
Other serious injury					
Surgeries					
Cancers					
HIV/AIDS					
Other					
Mental Health Concerns					
Alcoholism					
Anorexia					
Anxiety/panic attacks					
Attention deficit disorder					
Bipolar disorder					
Bulimia					

Compulsions					
Depression					
Dissociative experiences					
Drug use/abuse					
Learning disorder					
Obsessive thoughts or behaviors					
Paranoia					
Psychiatric hospitalizations					
PTSD					
Schizophrenia/psychosis					
Sleep problems					
Tobacco use					

Please give age, lists of any illnesses, or if deceased. If deceased, list causes of death and age of death:

Mother:

____

____

Father:

____

____

Siblings:

____

____

____

____

Mother's parents:

____

____

____

Father's parents:

____

____

____

Medical Information

PAIN

Please check the areas of pain or discomfort on the figures below.

Use a 0-10 scale to rank your pain from 0 (no pain at all) to 10 (the worst pain imaginable).

You can use the letters below to identify the type of sensation. Feel free to add any others you wish.

A = Ache

B = Burning

M = Memory Site

N = Numbness

P = Pins and needle

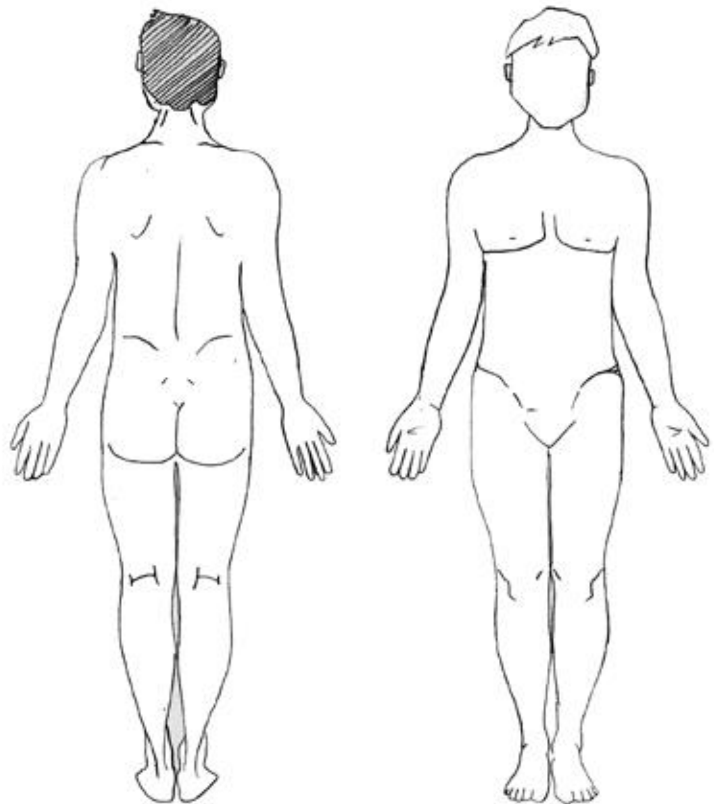
S = Sharp

Sc = Scar or surgery

St = Stabbing

R = Radiating

T = Trauma



Additional Information:

____

____

What Helps the Pain?

____

What Makes it Worse? ____

Please list any medications, pharmaceuticals that you are currently or have previously have taken:				
Medication	Dose	Frequency	For?	How long?
Eg, Zoloft	200 mg	At night before bed	Depression, migraine	Since 2011

Please list any supplements, herbs, vitamins, minerals, amino acids, and hormones that you are currently or have previously taken					
Supplement	Manufacturer	For?	Dosage	Frequency	How long?
Eg, Vitamin C	Solgar	Immune support	500 mg	1x/day	Since 2017

Please indicate if you have received any of the following treatments.					
	Type of Treatment/Provider	Conditions Treated	Duration of Treatment	Frequency of Treatment	Did it help?
	Chiropractic				
	Dietician				
	Health Coaching				
	Energy Therapy/Reiki				
	Nutritional Counseling				
	Psychotherapy				
	Supervised treatment with psychadelics				

Additional Health History

List and include dates and treatments. Add pages if necessary

Surgeries

____

Accidents

____

Major Illnesses

____

Please delineate your history of psychological counseling. Begin with most recent, working backward.

Provider Name	Provider Type (counselor, psychologist, psychiatrist)	Years of Treatment	Type of Treatment (Addictions counseling, mental health therapy, medication management, etc)	Treated for??(Reason you sought care)	Other Notes: why treatment ended, special details about care, etc.

Hospitalization History Please delineate your mental health hospitalization history, beginning with the most recent hospitalization. Please include any treatment in Intensive Outpatient Programs, or IOP. You may also include hospitalizations for substance use struggles.				
Dates of admission and discharge	Name of Hospital/Facility/Program	Reason for admission	Conditions of discharge	Voluntary/involuntary?

Drug and Alcohol Use History Please indicate which drugs you have tried, used habitually, and any with which you have struggled.				
Drug Used	Age of first use	Amount used within last month	Last use was…	Any treatment for use?

Self-Harm

Have you ever thought about hurting yourself? ____

Have you ever thought about ending your life? ____

Have you ever been hospitalized because of suicidal thoughts or feelings?

____

Have you ever hurt yourself or engaged in self-injury such as by cutting

yourself?____

Have you ever required medical treatment for self-injury? ___________________________________

When was the last time you engaged in self-injury? ____

Have you ever required medical treatment due to thinking about or attempting to end your own

life or hurting yourself? ____

When is the last time you thought about ending your own life, dying, or hurting yourself?

____

If recent, how many times in a week are you experiencing these thoughts and feelings?

____

Have you ever attempted suicide? ____'

If so, by what means?____

How many times have you attempted suicide? ______________________________________

Please note any serious medical procedures				
Procedure	Date(s)	What was it for?	Doctor coordinating?	Helpful?
E.g., Hysterectomy	July 2015	Endometriosis	Dr. Yan	After I healed, yes. But there were serious complications.

History of Homelessness

Have you ever been homeless?

____

For how long were you homeless?

____

How did you become homeless?

____

____

____

How did you find your way out of homelessness?

____

____

____

Do you currently have any legal concerns or legal issues/cases pending?

Please share your history of legal concerns and incarceration

Date of arrest	Alleged crime	Where crime allegedly occurred	Were you incarcerated?	Dates of incarcerations

What kinds of activities and exercises do you do?				
Activity	Minutes	1-2x week	2-4x week	5+x week
Artwork (painting, drawing, photography, ceramics, sewing, etc)				
Animal husbandry (caring for pets and service animals, feeding and playing with them, etc)				
Biking (in and outdoors)				
Car and/or motorcycle maintenance, restoration, etc.				
Church (attending, teaching classes, going to religious study)				
Cleaning (vacuuming, laundry, dishes, tidying up) and taking care of home				
Cooking				
Dancing (line, ballet, tap, hip-hop, etc)				
Eating				
Exercise classes (Zumba, step aerobics, etc)				
Gardening (and yardwork)				
Golfing				
Horseback riding				
Hiking and camping				
Gaming				
Internet "surfing"				
Meditation				
Music(singing, instrument, writing)				
Pilates				
Reading				
Running				

Shopping (groceries, clothing, household goods, etc)				
Swimming				
Tai Chi/chi gong				
Tennis				
Skiing				
Visiting with friends and family				
Volunteering (hospitals, nursing homes, animal shelters, food banks, etc)				
Walking				
Watching (Netflix, Hulu, TV, Movies, etc)				
Weight lifting				
Woodworking				
Working at a paying job (including preparing for professional work)				
Writing (fiction, non-fiction, poetry, etc)				
Yoga				
Other				

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Authorization for Release of Health Information Pursuant to HIPAA

Patient	DOB	SS#
Address		

I or my authorized representative request that my health information regarding my care and treatment be released in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996.

I understand that

1. This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment except psychotherapy notes, and confidential HIV-related information only if I place my initials on the appropriate line. In the event of health information described below includes any of these types of information and I initial the line on the box I specifically authorize release of such information to the person(s) indicated.
2. If I am authorizing information about HIV, alcohol or drug treatment or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under Federal or State Law. I understand that I have the right to request a list of Disclosures (people who may receive or use my HIV-related information without authorization.) If I experience discrimination because of the release of disclosure of HIV-related information I may contact the Delaware State Division on Human Rights. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient except as noted above in item 2, and this re-disclosure may no longer be protected by Federal or State law.
6. This authorization does not authorize you to discuss my PHI with anyone other than the individual (S) or agencies specified below:

Name and address of entity to release this information:

____

Specific information to be released:

___ Medical record from ____________________ to _________________________

___ Entire medical record including patient histories, office/progress notes EXCEPT PSYCHOTHERAPY NOTES, test results, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

___ Other:____

Include:

__Alcohol/drug treatment
__Mental Health Information
__HIV-related information

____

Signature

____

Dr. Jenna Tedesco