

**THE REHABILITATION CENTER,
THERAPEUTIC SOLUTIONS FOR CHILDREN AND ADULTS
1216 Hillcrest . 2009 Texoma Pkwy . Sherman . Texas . 75092 . (903) 893-7457**

DATE: _____ PATIENT NAME: _____ SOCIAL SECURITY# _____

SOCIAL WORK SCREENING FORM

FINANCES:	DIFFICULTIES NOTED: Is this client doing without food or medical attention? REFERRALS/ADVOCACY TO:	YES NO	NO NO
TRANSPORTATION:	DIFFICULTIES NOTED: Does the family have a car? REFERRALS/ADVOCACY TO:	YES NO	NO NO
EDUCATION/EMPLOYMENT:	DIFFICULTIES NOTED: Is this client having severe problems In school, on the job that have not already Been addressed? REFERRALS/ADVOCACY TO:	YES NO	NO NO
MENTAL/EMOTIONAL HEALTH:	DIFFICULTIES NOTED: Is this client having severe problems With mental or emotional health that have Not already been addressed? REFERRALS/ADVOCACY TO:	YES NO	NO NO
Completed by: _____ Referred/Conferred with Social Worker; Date _____		YES	NO

**AUTHORIZATION FOR RELEASE OF INFORMATION
FOR PURPOSES *OTHER THAN* TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS**

I hereby authorize The Rehabilitation Center to release minimal necessary protected health information (PHI) to funders, media entities and others involved in fundraising or promoting Center services. This is requested to support efforts directed at fundraising, public relations, Telehtons, United Way Campaigns and promoting Center services. PHI may be subject to redisclosure by the recipient and is no longer protected under HIPAA's Privacy Rule.

- I understand that I have a right to receive a copy of this authorization.
- I understand that I have the right to revoke this authorization at any time unless the Center has taken action in reliance upon it.
- I understand that any cancellation or modifications of this authorization must be in writing and receive by the Center at 1216 Hillcrest, Sherman, Texas to be effective.
- I understand that I have the right to refuse to sign this form and that the Center shall not condition treatment upon my signing this authorization.

This consent shall remain valid until revoked by you or sooner as indicated here _____.
I hereby release The Rehabilitation Center from liability that may arise from disclosure made pursuant to this authorization.

Signed: _____ Staff Signature: _____
 _____ Date: _____
 Relationship to Client