Consent for the Use or Disclosure of Protected Health Information

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As required by the Health Insurance Portability and Accountability Act of 1996 this practice may not use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

CONSENT SECTION

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

_____ _____

Signature Date

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

_____

_____

_____

_____

_____

_____ _____

Signature Date

REVIEWER SECTION

The terms of this request are / are not (circle one) acceptable.

_____ _____

Signature Date

Brian Carr, Ph.D. Privacy/Security Committee Members

Print Name Title

Reviewer's comments:

_____

_____

_____

_____

_____

REVOCATION SECTION

I hereby revoke this consent.

_____ _____

Signature Date

Consent in the Case of Minor Children or Couples Therapy

There are certain situations where the issue of records and their release can be complicated by the passage of time or the question of who must give consent in order for records to be released. In cases of working with minor children there may be issues related to authority granted by the courts (in the case of divorce) or other parental rights. In situations where couples or families are seen the clinical record may have information on each person that is commingled (mixed) in the progress notes that are generated with each contact. It is essential at the outset of receiving services that these situations are discussed and consent is obtained.

As Regards Minor Children

I, _____ (print name) hereby consent to the use and disclosure of my minor child's personal health information for the purposes of treatment, payment and health care operations as previously outlined in this document.

I understand that the release of this information will be governed by the relevant national and state standards and by any specific directives of any courts that may have ruling. I agree to provide any court documents that establish the legal standing of either parent and to provide updates to this status as they occur.

By my signature below I attest to my legal status to direct the health care of my minor child. To the extent allowed by law I understand that the other parent or legal guardian may request, receive, or consent to the release of records of this minor child.

_____ _____

Signature and Date Witness

As Regards Couples/Family Counseling

We (print name(s) below) hereby consent to the use and disclosure of our personal health information for the purposes of treatment, payment and health care operations as previously outlined in this document.

Print Names Below

We understand that the narrative records that are generated in the course of professional services will include references to all persons present during the session. By our signature below we individually agree and consent to any one of the person involved in receiving services be authorized to review or release these records in the future without reservation except as otherwise governed by national or state guidelines.

_____ _____

Signature and Date Signature and Date

_____ _____

Signature and Date Witness and Date