

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a “privacy rule” to help ensure that personal health information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their clients’ consent for uses and disclosures of health information about the client to carry out treatment, payment, or health care operations.

As our client, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest. This may include contacting your current medical providers insofar as information about your mental health may facilitate your overall healthcare.

We fully support your access to your personal medical records inasmuch as doing so would not be expected to threaten your welfare. We or our associates may have indirect treatment relationships with you (such as laboratories that only interact with your physician or therapist and not with you or the identified client), and may have to disclose personal health information for the purposes of treatment, payment or health care operations. These entities are most often not required to obtain client consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Clients) to request restrictions and revoke consent in writing.

Print Name	Signature	Date
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Print Name	Signature	Date
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For billing purposes, please print below the person(s) we may contact on your behalf and their relationship to you, if necessary to discuss insurance and/or payment. If you believe they are responsible for payment, they must sign an agreement to pay before services may be given.

Name	Relationship	Phone
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