Pathways to Wellness
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Acknowledgement of Receipt of "Notice of Privacy Practice" & "Office Policies and General Information"

I have received a copy of this Office's Notice of Privacy Practices and agree to its contents. I have read the Office Policies and General Information Agreement carefully; I understand both documents and agree to comply with them:

Client name (print): _____

Client Signature: _____ Date: _____

Signature of Parent/Guardian: _____

Consent to Use or Disclose Information for Treatment, Payment, and Health Care Operations

Client Name (please print) _____.

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to ***provide treatment to you***, to ***obtain payment*** for the services we provide, and for other professional activities (***known as "health care operations" such as insurance billing***). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____