

CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION (HIPAA part 2)

Your private health information is important to me and I will try to always protect it. **This form is one required by federal law.** It is somewhat complicated because there are many things I am required to say in it. It also relates to an even longer form, the **Notice of Privacy Practices**, which you need to read before you sign this one.

I authorize **RuthAnn Parvin** to use and disclose my health and clinical information for the following purposes: Treatment, Payment and Health Care Operations.

<p>Treatment includes providing care to you, coordinating your care with other professionals, and consultation with other experts to improve your care. It includes sharing information with your medical doctor or future therapists, if you ask me to do so.</p>	<p>Payment includes disclosures required for certification of sessions from your insurance carrier if you are using insurance, billing, receiving payment from your insurance company, reviews and quality control practices required by your insurance company.</p>	<p>Health Care Operations include administrative and business functions such as billing, collections for unpaid bills, filing of charts, and mailings from this office to you. These operations are handled by staff who are trained in confidentiality and legal issues.</p>
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I may, at some time in the future, change some of the policies of how I protect your personal healthcare records. I will keep an updated copy of my Notice of Privacy Practices on the bulletin board in my waiting room with the most recent date of changes displayed on the front page. Furthermore, you will be given a copy of the **Notice of Privacy Practices** at your request.

You have a right to request me to restrict the disclosure of your health information (as listed in the boxes above). You should provide this to me in writing. By law I am not required to grant this request, but if I do agree, this becomes a binding agreement unless disclosure is needed because you are needing emergency treatment.

When I am out of town or ill, I have another mental health provider take emergency calls from my clients. This person will be covered by this consent form and my **Notice of Privacy Practices**.

You have the right to revoke your consent at any time. It must be in writing. You may not revoke your consent for any information that I have used or disclosed prior to your written revocation. If you revoke your consent for me to provide information to your insurance company, you will be required to pay any bills then owing for therapy you have already received.

I was given a copy of the Notice of Privacy Practices (initial) _____

I understand and accept the terms of this form.

Signed: _____ **Date:** _____

Please print your name here: _____