Consent and Acknowledgment

Consent and Agreement to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I understand that as part of my care, you originate and maintain 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 professionals who contribute to my care,
- $ A source of information for applying my diagnosis and information to my bill,
- $ A means by which a third-party can verify that services billed Ire actually provided,
- $ And a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals and the services that are offered.

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures (release of, or access to, your information). I understand that I have the right to review the notice prior to signing this consent. I understand that you reserve the right to change the notice and practices. However, prior to a material change taking effect, you will publish an announcement of the change at your offices and on your website. I understand that a new Notice will be distributed to me.

I understand that my records are subject to confidentiality imposed by state and federal regulations and the NASW Code of Ethics, and that my records may not be released or disclosed without my written consent unless otherwise provided for in the regulations or the code.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that you are not required to agree to the restrictions requested, however if you agree to the requested restrictions, you are bound by our agreement.

By signing this form, I consent to your use and disclosure of protected health information about me for treatment, payment and health care operations. I understand that I may revoke this consent in writing, except to the extent that you have already taken action based upon my prior consent. I further acknowledge that I have received the Notice of Privacy Practices from you.

_____
Name of Individual Receiving Services (please print)

_____
Signature of Individual Receiving Services
Or Legal Representative

_____
Witness

_____
Date

04/13/2003
Notice Effective Date or Version