

INTAKE

PRACTICE POLICIES

HIPPA PATIENT CONSENT

For use and/or disclosure of protected of protected health information to carry out treatment, payment and healthcare operations.

I, _____, hereby state that by signing this consent, I acknowledge and agree as follows:

The Practice's Privacy Notice has been provided to me prior to my signing this consent. The privacy notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out its health care operations.

The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing the consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand, and consent to, the following that will be used:

- Telephoning my home or cell, and leaving a message on my voice mail
- Corresponding by e-mail or text

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed or carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. However if the practice agrees to a requested restriction, then the restriction is binding on the practice.

I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent in writing at any time for all future transactions, with the understanding that any such revocation will not apply to the extent that the Practice has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the privacy notice then the practice will not treat me.

I have read and understand the forgoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

patients name

parent/guardian signature

date

Danielle Kupperman, LCSW



www.breatheandbloomtherapy.com