Birchwood Counseling, LLC

Client Consent to the Use and Disclosure of Health Information (HIPAA)

Birchwood Counseling, LLC is required to provide this notice to you by the Health Insurance Portability and Accountability Act (HIPAA).

I, _____understand that as part of my health care, Birchwood Counseling, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care of treatment. I understand information serves as:

- A basis for planning and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Birchwood Counseling, LLC is not required to agree to the restrictions requested. I understand that I may revoke in writing, except to the extent that the agency has already taken into action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this agency may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Birchwood Counseling, LLC reserves the right to change their notice and practices prior to implementation in accordance with Section 164.520 of the Code of Federal Regulations. Should Birchwood Counseling, LLC change their Notice, they will send a copy of any revised notice to the address I have prided (whether by U.S. mail, or if I agree, email).

I understand that as part of this agencies treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Federal regulations require that Birchwood Counseling, LLC obtain proof that clients have received the Notice of Privac Practices. My signature below indicates that I have received a copy of Birchwood Counseling, LLC Notice of Privacy Practices.

_____ _____ _____

Client printed name Signature Date

_____ _____ _____

Legal Guardian/Parent Printed name Signature Date