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

Patient Name ______________________________________

Organization Granted this Consent: ***Covenant Counseling, Midland, MI***

Confidentiality:

We want you to know that we regard confidentiality an important component of effective therapy and privileged communication a right of all clients according to the law. Exceptions to this confidentiality are as follows:

- If the client requests that we bill their insurance company or a third party, diagnosis and dates of service are shared to collect payments when required.
- When the client signs a release of information.
- Mandated reporting of physical or sexual abuse of children, threats of suicide or homicide and those required by law. As a mental health practitioner, I will under no circumstances inform such individuals without first sharing that intention with the client, unless it is not possible to do so. Every effort will be made to resolve the issue before such a breach of confidentiality takes place.
- Information necessary for supervision or consultation of therapy.
- Information handled as outlined in the HIPAA Notice of Privacy Practice.

Records: Records are kept concerning your therapy. If you prefer your therapist keep no records, you must give a written request to this effect for your file. If this is done, the only record kept will be the date of your attendance. Without a record, requests from third party payers such as insurance companies cannot be made.

Couple Counseling Policy:

If you and your partner decide to have some individual sessions along with your joint therapy sessions, what you say in individual sessions is considered to be part of the couple's therapy and the information maybe discussed in joint sessions.

HIPAA Regulations:

In our effort to keep privileged information confidential and at the same time provide treatment, federal regulations allow us to use or disclose protected health information 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" (for example, quality improvement activities).

With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

These uses and disclosures are described more fully in our **Notice of Privacy Practices.** You have the right to review that Notice 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 waiting room. 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 allowed 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.

Phone Contact:

We, at times, phone to remind our clients of their appointment or to be in contact for various reasons. **Please indicate below the ways you would like to be contacted by writing your initials in the corresponding boxes:**

Home	
Work	
Cell phone	

Give us any contact instructions: ____.

I hereby consent to the use or disclosure of my protected health information as specified above.

______________________________ ______________________

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: ______________________________