1610-A Graves Mill Road
Lynchburg, VA 24502
Phone 434-205-8049
Fax 833-402-0997

HIPAA

Consent to use and disclose your health information

This form is an agreement between you, _____, and _____, LPC. When I use the word "you" below, it will mean you, your child, relative or other person if you have written his or name here:_____.

When I evaluate, diagnose, treat, or refer you I will be collecting what the law call Protected Health Information (PHI). I need to use this information here to decide what treatment is best for you and to provide that treatment. I may also be required to share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions. My standard procedure is to ask for your written consent prior to providing PHI because in addition to the following HIPPA guidelines, I also follow professional guidelines that are more restrictive.

The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form.

According to HIPAA policy, if you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, I may change how I use and share your information and so may change my Notice of Privacy Practices. If I do change my notice, you request a copy from our privacy officer by calling 434-219-5621.

If you are concerned about some of your information, you have the right to ask me not to use or share some or all your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

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I have received the Notice of Privacy Practices and have been given an opportunity to review it.

Client Name: (Please print): _____ Birth Date: _____

Client Signature: _____ Date: _____

OR

Printed Name of Guardian or Representative: _____ Relationship to Client: _____

Signature of Guardian or Personal Representative: _____ Date: _____

Therapist Signature: _____ Date: _____

Date of NPP copy reviewed by guardian: _____