

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and Stacey N. Paley. When the word “you” is used below, it will mean your child, relative, or other person if you have written his or her name here.

When I examine, diagnose, treat or I send you to a referral, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also 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. Federal regulations (HIPAA) allow me to use or disclose PHI from your records in order to provide this treatment.

By signing this form you are agreeing to let me use your information here in this practice and send to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read the Notice before you sign this Consent form.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment or health care operations; however, I do not have to agree to those restrictions. If I do agree to a restriction, that agreement is binding.

In the future I may change how I use and share your information and so may change the Notice of Privacy Practices. If I do change it, I will notify you during our session and give you a copy. You can also obtain a copy by writing to me at spaley.healthyminds@yahoo.com or by calling 215-489-0900.

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.

The consent is voluntary; you may refuse to sign it. However, **I will not be able to treat you.** If the consent is later revoked, **I will no longer be able to see you as a patient.**

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Limits of Confidentiality

The law protects the privacy of all communications between a patient and a therapist. In most situations, we can only release information about your treatment to others if you sign a Written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this agreement provides consent for those activities as follows:

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are legally bound to keep the information confidential. If you don't object, we

will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in our notice of Notice of Privacy and Practices form.

There are some situations where I am permitted or required to disclose information without either **your consent or authorization**. Most of these are covered in your HIPAA NOTICE. They also include:

If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

If a patient files a complaint or lawsuit against me, I am permitted to disclose relevant information regarding that patient in order to defend the therapist or the practice.

I hire a group to handle the billing for this practice. In most cases I will have to share your information with these individuals for administrative purposes. As required by HIAA, I have a formal business associate contract with this business in which they promise to maintain the confidentiality of his data, except as specifically allowed in the contract or otherwise required by law. The companies name is: JABZ- MEDICAL BILLING SERVICE- (215) 230-7550 email jabzclaims@aol.com

Your Signature Below indicates that you have read this agreement and agree to its terms:

Signature of Patient: _____ Date: _____