PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

Phone/Email: _____

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Blue Moon Senior Counseling will not release confidential information, in person or by telephone, email or fax to any unauthorized people. When returning phone calls, we will not leave a message on an answering machine or voicemail without written consent. Information may not be given to an unauthorized person who may answer your phone. If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please specify below. I understand and authorize Blue Moon Senior Counseling to release confidential health information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify Blue Moon Senior Counseling if the authorization information changes.

I consent to Blue Moon Senior Counseling being able to leave messages for me on my:

__Home Phone: _____ __Mobile phone _____

__Other: _____

I consent to Blue Moon Senior Counseling to share confidential information regarding my care to:

Name/ Entity	Relationship	Phone/Fax

I authorize this information to be disclosed in the following ways:

__Written/photocopy/paper __Verbal ___Fax ___Email ___Other:

Specific description of the Protected Health Information that I authorize for disclosure:

___Progress Notes ___Entire Health Record (Including but not limited to information regarding medical/health treatment, insurance, demographics, referral documents, etc) ___Treatment Progress

___Other: _____

I give specific authorization for the following to request disclosures of my health information:

__At the request of the individual (patient)

__At the request of Other: (List names/Relationships)_____

_____

This authorization is valid, unless a specific expiration date or event is specified here: _____

I understand I may revoke this authorization at any time in writing. I am entitled to make a copy of, or request to receive a copy of this authorization. I acknowledge by my signature below that I have read and understand this authorization, it accurately reflects my wishes, and a photocopy, facsimile, or other electronic copy is as valid as the signed original.

_____ _____

Signature of Patient/POA/Guardian DATE

_____

Printed name of Patient/POA/Guardian

CONSENT FOR SERVICES

Patient Name: _____ Phone: _____

Email: _____ DOB: _____

Address: _____

ASSIGNMENT OF BENEFITS

By signing below, you are authorizing the release of necessary information about your case to your primary and if applicable, secondary insurance to process your insurance claim. You are also assigning benefits to Blue Moon Senior Counseling for any eligible payments from your insurance carrier. This is a direct assignment of the rights and benefits under the insurance policy. Your signature below will serve as a signature on file and may be revoked in writing at any time.

CONSENT TO TREATMENT

I authorize and request that a Blue Moon Senior Counseling clinician, provide psychotherapeutic assessment and treatment which now and/or during the course of my care as a patient are advisable. I understand my therapist may change for various reasons and this consent is for any Blue Moon Clinician to provide treatment. The frequency and type of treatment will be decided between my therapist and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I understand maximum benefit will occur with consistent attendance and at times I may feel conflicted, as the process can sometimes be uncomfortable. I agree to the 24-hour notice of cancellation policy. I understand the limits of confidentiality regarding my treatment. Those limits have been described to me as: if I am a danger to myself or others, in child or adult abuse cases and/or if there is a subpoena for records by a court of law. I have read and fully understand this form.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Blue Moon Senior Counseling** may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to **Blue Moon Senior Counseling's** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that **Blue Moon Senior Counseling** reserves the right to revise its Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, (10204 Bode St STE B Plainfield IL 60585).

With my consent, **Blue Moon Senior Counseling** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care. With my consent, **Blue Moon Senior Counseling** may mail to my home or other designated location any items that assist the practice in carrying out TPO as long as they are marked Personal and Confidential. With my consent, **Blue Moon Senior Counseling** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO. I have the right to request that **Blue Moon Senior Counseling** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form I am consenting to **Blue Moon Senior Counseling** use and disclosure of my PHI to carry out TPO. At any time, I may revoke my consent in writing, by sending a signed and dated written statement to Privacy Officer (10204 Bode St STE B Plainfield IL 60585), saying that I am revoking my authorization to disclose health records, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Blue Moon Senior Counseling** may decline to provide treatment to me. I understand this consent will automatically renew in 1 year unless otherwise specified: _____

Signature of Patient/POA/Guardian: _____

Date: _____

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to: Get a copy of your paper or electronic medical record, correct your paper or electronic medical record, request confidential communication ask us to limit the information we share, get a list of those with whom we've shared your information, get a copy of the privacy notice choose someone to act for you or file a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way that we use and share information as we: Tell family and friends about your condition, provide disaster relief, include you in a hospital directory, provide mental health care, marker our services and sell your information or raise funds.

Our Uses and Disclosures

We may use and share your information as we: Treat you, run our organization, bill your services, help with public health and safety issues or do research.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on page 2.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

• We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care, Share information in a disaster relief situation, Include your information in a hospital directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:
Marketing purposes, Sale of your information, Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you : We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization : We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services : We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety

Do research : We can use or share your information for health research.

Comply with the law : We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests : We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you: For workers' compensation claims, For law enforcement purposes or with a law enforcement official, With health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see : www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. Effective July 21, 2016
A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, (10204 Bode St STE B Plainfield IL 60585).