# Consent to the Use & Disclosure of Health Information

***The privacy of your Protected Health Information is protected by HIPAA and the AMHCA Code of Ethics. However, Partners in Family Wellness, PLLC is permitted by HIPAA to use and disclose your protected health information, with certain limits and protections, for treatment, payment and health care operations activities. Pursuant to HIPAA, you have the right to request restrictions on Partners in Family Wellness, PLLC's use and disclosure of your protected health information for treatment, payment or health care operations activities. Partners in Family Wellness, PLLC is not required to agree to your request for restrictions, but if Partners in Family Wellness, PLLC does agree to your request, it is bound by that agreement and cannot use or disclose your protected health information in a manner inconsistent with an agreed-upon restriction.***

Today's Date: _____

_____
Patient's Name

_____
Patient's Birth Date

_____
Patient's Address

_____ _____
Home Telephone Mobile Telephone

I request that ***Partners in Family Wellness, PLLC*** restrict the use and disclosure of my protected health information ("PHI") for purposes of treatment, payment or healthcare operations as follows:

_____
_____
_____
_____

1. I understand that ***Partners in Family Wellness, PLLC*** is not required by HIPAA to agree to this restriction, unless the restriction concerns a disclosure to a health plan for purposes of carrying out payment or health care operations and such disclosure is not otherwise required by law and the restriction concerns PHI which pertains solely to a health care item or service for which ***Partners in Family Wellness, PLLC*** has been paid out of pocket by me in full.

2. If ***Partners in Family Wellness, PLLC*** agrees to this restriction, I understand the restriction may be terminated at any time if permitted by mental health counselor ethical and state confidentiality rules. A termination of this restriction is effective for PHI that ***Partners in Family Wellness, PLLC*** creates or receives after the date it informs me of such termination. Restrictions concerning a disclosure to a health plan for purposes of carrying out payment or health care operations where such disclosure is not otherwise required by law and concerns PHI which pertains solely to a health care item or service for which ***Partners in Family Wellness, PLLC*** has been paid out of pocket by me in full will not be terminated unless I request such termination in writing.

3. Even if the request is granted, I understand that restricted PHI may be used or disclosed to provide emergency treatment for me or as otherwise required by law. However, the emergency treatment provider will be asked not to redisclose any restricted PHI.

4. I understand that in accordance with other applicable law, the types of uses and disclosures I have written above may or may not be otherwise permitted.

5. I also understand that my right to request restrictions under this HIPAA provision only extends to use or disclosure for treatment, payment or health care operations. My right to authorize the use and disclosure of protected health information for other purposes (or to withhold consent) is addressed in separate policies and the HIPAA Notice of Privacy Practices.

6. I will be notified in writing of the action taken on this request. If a request is not specifically listed above and agreed to in writing, it will not be effective.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Guardian (if applicable) Date

For Organization Use Only:

Date Request Received: _____

Date of Written Response: _____

Action taken (CHECK ONE): ☐ Granted ☐ Denied (if denied, state reason below)

_____

_____ _____

Signature of Staff Person Date



Revised 9/5/13