choices
BEHAVIORAL HEALTH SOLUTIONS

Authorization for Release of Protected Health Information (PHI)

Client Information (Please Print)

Name: Date of Birth: Age:

Street Address: City: State: Zip:

Home Phone: Cell Phone:

I hereby authorize Choices Behavioral Health Services to: (Please Check All That Apply)

☐ **Release** Information To: ☐ **Obtain** Information From: ☐ **Verbally Exchange** Information With:

Name and Relationship of Individual or Organization: Phone Number: Fax Number:

Street Address: City: State: Zip Code:

I authorize the following information to be released: (Please Check All That Apply)

☐ Assessments ☐ Physician Notes ☐ Discharge Summary ☐ Medication List
☐ Treatment Plan ☐ Psychological Eval ☐ Psychiatric Eval ☐ Current Diagnosis
☐ Reports (i.e., school, court, DCS, probation) ☐ Treatment Summary ☐ Medical Records
☐ Other (Please Specify): _____

Release for Special Protected Information:

This authorization is valid for disclosure of alcohol and/or substance abuse, communicable disease, and HIV/AIDS information. If you do not want Choices to share certain information, please check and initial below:

1. The diagnosis or treatment of alcohol and/or substance abuse ☐ No _____ (initial)
2. The diagnosis or treatment of AIDS, including the results of HIV tests, or communicable disease ☐ No _____ (initial)

Purpose for Disclosure (Please Check All That Apply)

☐ At the request of the client (or legal guardian) ☐ Continuity of Care ☐ Treatment Planning
☐ Other (Please Specify): _____

Method Protected Health Information is to be released (Check One)

☐ Verbally ☐ Photocopy ☐ Fax ☐ CD ☐ Other (Please Specify): _____

Expiration Date: This authorization will expire in 180 days unless otherwise indicated below:

☐ This authorization will expire upon the following date or condition: _____
☐ This authorization will expire 60 days past termination of services at Choices

Additional Rights

I understand that I have the right to revoke this authorization at any time, by providing written notification to Choices. I understand the revocation will not apple to information previously released in response to this authorization.
I understand that a copy or facsimile (Fax) of this authorization is as valid as the original.
I understand that I have the right to receive a copy of this authorization. Copy of authorization received. ☐ _____ (initial)
I understand that I am not required to sign this authorization and that my treatment will not be affected if I refuse to sign this authorization.
I understand that information released/disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it will no longer be protected by this authorization.

_____ _____
Client Signature Date Parent/Guardian Signature Date

_____
Witness Signature Date

CHOICES BEHAVIORAL HEALTH SOLUTIONS

NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND TREATMENT INFORMATION ABOUT YOU (WHICH INCLUDES YOUR MINOR-AGED CHILD, IF HE/SHE IS THE IDENTIFIED CLIENT) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Provided in compliance with 45C.F.R. § 164.520

Choices Behavioral Health Solutions and its affiliated entities (collectively "Choices") use health information about you for treatment, to obtain payment for treatment, to evaluate the quality of care you receive, and for other administrative and operational purposes. Your health information is contained in a clinical record that is the physical property and responsibility of Choices. This Notice describes the use and disclosure of protected health information (PHI) by employees, staff, personnel, volunteers and other professionals authorized to enter information into your clinical record.

Your Rights

You have the following rights with respect to protected health information about you:

Right to Copy of Notice of HIPAA Privacy Practices. You have the right to a paper copy of this Notice at any time. To obtain a copy of our current Notice of HIPAA Privacy Practices, please contact the Choices Privacy Officer at the address or phone number listed below.

Right to Inspect and Copy. You have the right to inspect and/or obtain a copy of health information that may be used to make decisions about your care. This includes medical and billing records but does not include psychotherapy notes. Your request must be in writing to the Choices Privacy Officer at the address listed below. If you request a copy of your health information, we will charge you a fee to cover the costs of copying and mailing the information. In certain very limited circumstances, we may deny your request to inspect and copy your health information. If you are denied access to your medical information, we will document our reasons in writing. You have the right to request that another person at Choices review the decision. We will comply with the outcome of the review. For more information about this right see 45C.F.R. § 164.524.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. To request an amendment, your request must be made in writing and submitted to the Choices Privacy Officer at the address listed below. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for Choices;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If your request for an amendment is denied, we will explain our reasons in writing. You have the right to submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you. For more information about this right, see 45.C.F.R. § 164.256.

Right to an Accounting of Disclosures. You have the right to request an accounting or detailed listing of certain disclosures of your health information. The time period covered by the accounting is limited. Your request must be in writing to the Choices Privacy Officer at the address listed below. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting. For more information on this right, see 45.C.F.R. § 164.528.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing to the Choices Privacy Officer at the address listed below. Please be aware that we are not required to agree to your request for restrictions. If we agree to your request for a restriction, we will comply with it unless the information is needed for emergency treatment. For more information on this right, see 45.C.F.R.§ 164.522.

Right to Request Alternative Method of Contact. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing to the Choices

Privacy Officer at the address listed below. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request an alternative address for billing purposes. For more information on this right, see 45.C.F.R. § 164.522(b)

Choices' Obligations

We understand that medical information about you and your health is personal. We are committed to protecting your personal health information. We create a record of the care and services you receive at Choices. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by Choices. By law, we are required to:

- maintain the privacy of protected health information;
- provide you with this Notice of our legal duties and privacy practices with respect to your health information;
- abide by the terms of the Notice of HIPAA Privacy Practices currently in effect;
- notify you if we are unable to agree to a requested restriction on how your health information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations;
- obtain your written authorization to use or disclose your health information for reasons other than those identified in this Notice and permitted by law;
- comply with your state's laws if they provide you with greater rights over your health information or provide for more restriction on the use or disclosure of your health information;
- release medical information for judicial or administrative proceedings pursuant to legal authority;
- report information related to victims of abuse, neglect, or domestic violence;
- assist law enforcement officials in their law enforcement duties;
- learn how to improve our facilities and services; determine how to continually improve the quality and effectiveness of the health care we provide; and
- conduct training programs or review competence of health care professionals.

Uses or Disclosure of Your Protected Health Information

Treatment. We may use and disclose health information about you to provide behavioral health services. To this end, we may communicate with other health care providers, such as a psychiatrist, pediatrician or other ancillary medical provider, regarding your treatment. This information is necessary for your Choices behavioral health provider to determine what treatment you should receive.

Payment. We may use and disclose health information about you to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as Medicaid, an insurance company or a referral source. The information on the bill may include information that identifies you, your diagnosis, and treatment or supplies used in the course of your treatment. In some instances, we may disclose health information about you to an insurance plan before you receive certain health care products or services, to determine whether the insurance plan will pay for the particular product or service.

Health Care Operations. We may use and disclose health information about you for administrative and operational purposes. Members of the Performance and Quality Improvement Team may use health information about you to assess the care and outcomes in your case and others like it. The results will be used internally to continually improve the quality of care for all Choices clients. For example, we may combine outcome data from many clients to evaluate the need for new products, services or treatments. We may disclose information to health care

professionals, students and other personnel for review and training purposes. We may also combine health information we have with other sources to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy and to allow others to use the information to study health care without learning the identity of specific residents. We may also use and disclose medical information to evaluate the performance of our staff and your satisfaction with our services.

Business Associates. We provide some services through contracts with business associates, such as consultants, ancillary providers and vendors. When such services are contracted, we may disclose health information about you to our business associates so that they can perform the tasks that we have assigned to them. To protect your health information, we require the business associate to appropriately safeguard health information about you.

Alternative Treatments. We may use health information about you to provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you.

Appointment Reminders. We may use health information about you to provide appointment reminders.

Required by Law. We may use and disclose health information about you as required by federal, state and local laws. For example, we disclose health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct in the facility; and
- in emergency circumstances to report a crime; the location of a crime or victims; or the identity, description or location of the person who committed the crime.

Public Health. We may use health information about you for public health activities or for other health oversight activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births or deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products that they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- to notify the appropriate government authority if we believe a resident has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or if required or authorized by law.

Research. We may use or disclose health information about you for research purposes under certain circumstances. For example, we may disclose health information to a research organization if an institutional review board or privacy board has reviewed and approved the research proposal, after establishing protocols to ensure the privacy of your health information.

Health and Safety. We may use or disclose health information about you to avert a serious threat to your health or safety or any other person pursuant to applicable law.

Medical Examiners and Others. We may use or disclose health information about you to medical examiners, coroners, or funeral directors to allow them to perform their lawful duties. If you are an organ or tissue donor, we may use or disclose health information about you to organizations that help with organ, eye and tissue donation and transplantation.

Information Not Personally Identifiable. We may use or disclose health information about you in ways that do not personally identify you or reveal who you are.

Government Functions. We may use or disclose health information about you for specialized government functions, such as protection of public officials, national security and intelligence activities, or reporting to various branches of the armed services.

Workers Compensation. We may use or disclose health information about you to comply with laws and regulations related to workers compensation.

Correctional Institutions. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose health information about you. Such information will be disclosed to the correctional institution or law enforcement official when necessary for the institution to provide you with health care and to protect the health and safety of others.

Effective Date, Restrictions and Changes to This Notice

This Notice, pursuant to the Health Insurance Portability and Accountability Act (HIPAA), has been in effect since April 14, 2003. Choices reserves the right to change the terms of this Notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will provide you with a revised Notice in person or by mail. We will post a copy of the current notice in the Choices waiting area.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Choices Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with Choices, contact the Privacy Officer at the address or phone number listed below. You will not be penalized or retaliated against for filing a complaint.

Contact Information

If you have any questions, requests or concerns about your Choices-related health information rights or our use and disclosure of health information, please contact: Privacy Officer, Choices Coordinated Care Solutions, 7941 Castleway Drive, Indianapolis, Indiana 46250. Phone: 317-726-2121.

Choices Behavioral Health Solutions
Consent to Treat Form

INFORMED CONSENT FOR TREATMENT:
Welcome to Choices Behavioral Health Solutions (CBHS). This document contains important information about our services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI). Please read this document carefully and jot down any questions you might have so that they can be discussed with your therapist. This consent form represents an agreement between you and Choices Behavioral Health Solutions.

WHAT TO EXPECT:
The first session will involve an evaluation of your current situation and behavioral health needs. During the initial evaluation, the therapist will ask you and your parent/legal guardian for detailed information about current symptoms, strengths, concerning behaviors, supports and/or problems you may be having at home and at school. You may be asked to complete formal measures to help us better understand your needs. You and your parent/legal guardian may also be asked to sign consent for the therapist to contact other providers or educators who know you well. Any relevant medical, treatment, or educational records will be requested.

Based on this assessment, the therapist will share his or her working understanding of the problem areas, strengths, needs, treatment plan goals/objectives, and possible outcomes of treatment. If you or your parent/legal guardian have any unanswered questions about any of the procedures used, their possible risks, the therapist's expertise in employing them, or the treatment plan, please ask them at this time. You and your parent/legal guardian also have the right to ask about other treatment options, including potential risks and benefits. You should evaluate this information along with your own opinion of whether you feel comfortable working with the therapist.

Psychotherapy is not easily described in general statements. Choices Behavioral Health Solutions uses a variety of evidence-based treatment modalities, such as Trauma-Focused Cognitive Behavioral Therapy, to meet the individualized needs of each client. Regardless of the techniques used, psychotherapy and behavioral interventions can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you and/or your parent/guardian may experience uncomfortable feelings like sadness, guilt, anger, frustration, and helplessness. You parent/guardian may be asked to try new parenting practices that are different from those they have used before, which can feel uncomfortable at first.

On the other hand, psychotherapy has been shown to have benefits for people who go through it. Therapy often leads to better relationships, decreases in problematic behaviors, and significant reductions in feelings of distress. Therapists at Choices are committed to providing therapy that is deemed to be most appropriate for you and your family based on the needs identified and treatments supported by the professional literature.

STAFF QUALIFICATIONS:
All therapists working for Choices Behavioral Health Solutions have master's degrees in Social Work, Mental Health, Marriage and Family Therapy, Psychology or a related human services field. All

therapists are supervised by a Licensed Clinical Psychologist with HSPP (Health Services Provider in Psychology) endorsement. Therapists may receive additional supervision from a Licensed Clinical Social Worker (LCSW), depending upon the program in which they work. None of the CBHS staff are physicians. As a result, we cannot prescribe medication or perform medical procedures. If you are taking psychotropic medication(s), we will work closely with your family physician and/or prescribing provider to coordinate care.

MEETINGS:
The therapist will conduct an assessment during your first session. Input from you and your parent/legal guardian will be sought at this time to identify strengths/needs and to establish goals and objectives for treatment. Based on this information, your therapist will develop a Master Treatment Plan that summarizes the needs, goals, objectives, interventions and individuals responsible for your care. The Master Treatment Plan will be reviewed during the second session, and you will have an opportunity to provide additional input, additions and/or recommendations. Once everyone on the team is in agreement with the plan, you, along with your parent/legal guardian and therapist, will sign and date the Master Treatment Plan.

Your therapist will work with you to schedule counseling appointments that best meet your needs and schedule. Once appointments have been scheduled, we ask that you give 24 hours' notice if, for whatever reason, you need to cancel. Any appointment cancelled with less than 24 hours' notice will be considered a no-show appointment. Not being present for a scheduled appointment is also considered a no-show. Three no-show appointments in one year may result in termination from the program.

CONTACTING YOUR THERAPIST:
Your therapist may not be immediately available by telephone during work hours. You can contact the YES Home between 9:00 am and 5:00 pm Monday through Friday or leave a message on your therapist's cell phone. Your therapist will return your call as soon as possible, but no later than 24 hours after you leave a message. Please understand that telephone calls are not intended to take the place of counseling sessions.

EMERGENCIES:
In the event of a life-threatening emergency, please call one of the following emergency/crisis numbers before calling your therapist:

Emergency Services:	911	Sun Behavioral: 513-880-8217
Community Mental Health	812-537-1302	Cincinnati Children's 513-636-4124
St. Elizabeth	812-537-1010	Margaret Mary Hospital 812-934-6624

BILLING AND PAYMENT:
All CBHS services are billed through Medicaid and/or through contracts with the Indiana Department of Child Service (DCS).

CONSULTATION AND SUPERVISION:
Therapists with Choices Behavioral Health Solutions attend team staffings, receive individual supervision and consult regularly with other professionals regarding their clients. However, each client's identity remains completely anonymous when consulting with outside professionals, and confidentiality is fully maintained.

Some specific circumstances where CBHS Therapists might be required to participate in supervision or consultation include the following:

- State licensure regulations may require a therapist to receive ongoing supervision.
- Accreditation organizations, as well as insurance companies, may require that treatment plans be reviewed.
- Professional standards of care may recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others.
- Other special circumstances, such as preparation to testify in court.

ACCESS TO YOUR RECORDS:

All records will be maintained pursuant to HIPAA. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal and emergency circumstances or when your therapist assesses that releasing such information will be harmful in any way. If you wish to review your records, your parent/legal guardian can submit a written request to the Choices Privacy Officer. It is always recommended that you review treatment records with your therapist so the contents can be discussed and any questions you have can be answered. When more than one client is involved in treatment, such as in cases of family therapy, your therapist will release records only with signed authorizations from the adult who has been granted legal custody of the child.

Both the law and the standards of your therapist's profession require that Choices keep treatment records for a minimum of seven years after termination of services with the client or subject of evaluation, or three years after a client or subject of evaluation reaches majority, whichever is greater. Unless otherwise agreed to be necessary, Choices retains clinical records only as long as mandated by Indiana law. If you have concerns regarding your treatment records, please discuss them with your therapist.

CONFIDENTIALITY:

The law protects the privacy of all communication between a client and a therapist. In most situations, CBHS can only release information about your treatment to others if you sign a written Release of Information form that meets certain legal requirements imposed by HIPAA.

However, there are some circumstances where confidentiality cannot be maintained. We are required by law or by the guidelines of professional practice to disclose information without your consent in the following situations:

- If we have cause to believe that a child, dependent, elderly or disabled person has been abused, neglected or exploited, we must report that information, as required by law, to the appropriate authorities.
- If you disclose that you plan to cause serious harm or death to yourself, and we believe that you have the intent and ability to carry out this threat imminently, we must take steps to inform your parent or legal guardian, and we must ensure that you are protected from harming yourself.
- If you disclose that you plan to cause serious harm or death to someone else who can be identified, and we believe you have the intent and ability to carry out this threat imminently, we must inform your parent or guardian, law enforcement and the person you intend to harm.
- If you file a lawsuit against your therapist or Choices Behavioral Health Solutions, we may disclose information regarding your treatment.

- If a government agency requests information for health oversight activities, we may be required to provide it to them.
- If you are involved in a court proceeding, we may be ordered by the court to disclose information.

If any of these circumstances should arise, your therapist will make every effort to fully discuss it with you before taking action, if possible, and will limit disclosure to the minimum information necessary to meet legal and/or professional requirements.

MINORS AND PARENTS:
Clients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their minor-aged child's treatment records, unless the therapist believes that such a review would be harmful to the client and his or her treatment. Because privacy is often crucial to successful progress in psychotherapy, especially with adolescents, it is the policy of Choices Behavioral Health Solutions to request that parents/guardians agree to voluntarily give up consent to access their child's treatment records. If parents/guardians agree to this request, we will not share specific information from therapy sessions with them. This includes activities and behaviors that a parent/guardian would not approve of — or would be upset by — but that do not put the minor-aged client at risk of serious and immediate harm. However, if risk-taking behaviors escalate and become more serious, then we will use professional judgment to decide whether the client is in serious and immediate danger of being harmed. If we feel that the client is in such danger, we will communicate this information to the parent or guardian.

Even if your therapist must keep information confidential – to not tell your parent or guardian – he or she may believe that it is important for them to know what is going on in your life. In these situations, your therapist will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, your therapist may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you. Before giving parents or guardians any information, your therapist will make every effort to discuss the matter with you and to address any objections you may have.

SOCIAL NETWORKING AND INTERNET SEARCHES:
Therapists and staff with Choices Behavioral Health Services do not accept friend requests from current or former clients on social networking sites, such as Facebook. We believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For the same reason, Choices Behavioral Health Services requests that clients not communicate with therapists via any interactive or social networking web sites.

TERMINATION OF SERVICES:
Throughout the course of treatment, your therapist may determine that you are not benefitting from services. Likewise, you may decide for any reason, or at any time, to terminate services with Choices Behavioral Health Solutions. In either case, if appropriate, your therapist will provide you with names of other qualified professionals whose services might better meet your needs. If you and your parent/legal guardian request and authorize it in writing, the therapist will talk to the new provider to assist with transition planning.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES:

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It is very important to be aware that computers, cell phones and unencrypted e-mail, texts, and e-fax communications can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. In addition, it is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address, phone number or computer. Please indicate below if you are willing to allow communication via answering machine, voice mail and/or text message to arrange, modify and/or confirm appoints with CBHS. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

AGREEMENT AND CONSENT FOR TREATMENT:
Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Client Signature: _____ Date_____

Parent/Guardian Signature:_____ Date_____

Parent/guardians initial boxes and sign below indicating that you will respect your child's privacy:

_____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

_____ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's treatment.

_____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent/Guardian Signature _____ Date_____

Therapist Signature _____ Date_____

_____
Primary: Home/Cell Phone

Permission to leave message at this number (with person answering the Phone, answering machine and/or Voice mail) and/or to send text messages: Yes No

_____
Primary: Home/Cell Phone

Permission to leave message at this number (with person answering the Phone, answering machine and/or Voice mail) and/or to send text messages: Yes No

CHOICES BEHAVIORAL HEALTH SOLUTIONS

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my treatment, Choices Behavioral Health Solutions originates and maintains health records describing my health/mental health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the professionals who contribute to my care;
- a source of information for applying my diagnosis and placement information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided; and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of HIPAA Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ I request the following restriction to the use or disclosure of my health information.

_____

_____

_____

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature Date

☐ Accepted ☐ Denied

_____ _____ _____

Agency Representative Signature Title Date