Consent to Use or Disclose
Health Information for the Treatment, Payment, And Health Care Operations

Client Name: _____

Client Address: _____

Client Telephone Number: _____

In the course of providing service to you, HeartSphere Counseling, LLC creates, receives, and stores health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct health care operations.

HeartSphere Counseling, LLC has a comprehensive Notice of Privacy Practices that describes the uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in the Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health care professional (a specific Release of Information form will be required in these instances). The use and disclosure of your confidential information for purposes of payment may include the submission of your personal information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers of insurers for claims review, determination of benefits and payment; or our submission of your personal information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practice change. You can get an updated copy here at our office or from our website at www.heartspherecounseling.com.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform mental health treatment. You can revoke this consent in writing at any time unless we have already treated you, sought payment for services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or mental health treatment, but as described I our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we agree with the restrictions, the restrictions are binding with respect to information disclosed. The Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY CONFIDENTIAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Client Signature: _____ Date: _____

If you are signing as a personal representative of the patient describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Client: _____ Print Name: _____