HIPPA, PRIVACY PRACTICES & RELEASE OF INFORMATION

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REQUIRED: HIPPA & Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

At your request, we will provide you with a copy of the Health Information Privacy Policy Act (HIPPA)

I have received, read and understand your Notice of Privacy Practices (NPP) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NPP from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NPP; I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Client's Name - Printed | Parent or Legal Representative & Date

_____ _____

Client's Signature & Date | Other Signature (optional)

OFFICE USE ONLY

I attempted to obtain client's signature in acknowledgment on the NPP Acknowledgment, but was unable to do so as documented below:

_____ Individual refused to sign
_____ Communication barrier prohibited obtaining the acknowledgment
_____ An emergency situation prevented me from obtaining acknowledgment
_____ Other (please specify) _____

OPTIONAL: Release of Information for Continuum of Care & Treatment

This section should be completed if you want another counselor, psychiatrist or other healthcare professional to provide me with confidential medical, psychological, psychiatric, educational, and/or other appropriate information about you. This authorization shall be effective from the date of signing, unless otherwise noted.

PERSONS OR AGENCIES (Please initial each one to the right)

_____ _____

_____ _____

THIS IS A (Please choose one)

□ **Two-way release** of information, so that Christy Mellen and the persons or agencies listed above may communicate with each other and share information about my child or client.

□ **One-way release** of information, so that Christy Mellen may share information about my child or client with the persons or agencies listed above.

_____ _____

Client's Name - Printed | Parent or Legal Representative & Date

_____ _____

Client's Signature & Date | Other Signature (optional)

COMPLAINTS ABOUT THIS COUNSELOR MAY BE REPORTED TO:
TX DEPT OF STATE HEALTH SERVICES @ 1100 W. 49TH STREET AUSTIN, TX or 1.800.832.9623