The Next Step Counseling Services, LLC
Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, ________________________________, understand that as part of my healthcare, The Next Step Counseling Services originates and maintains paper and/or electronic records describing my health history, symptoms, diagnosis, 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 many health professionals who contribute to my care,
- A source of information for applying my diagnosis and services obtained to my bill
- A means by which a third-party payer can verify that services billed were actually provided

I understand and have been provided with a copy of the Privacy Notice that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the prior notice to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that The Next Step Counseling Services 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 the reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.
I further understand that The Next Step Counseling reserves the right to change their notice and practices and prior to implementation, in accordance to Section 164.520 of the Code of Federal Regulations. Should The Next Step Counseling Services change their notice, they will send a copy of any revised notice to the address I've provided.
I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of the agency's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent. (circle one)

________________________________ ________________________________

Signature/Date Witness/Date

I have received The Next Step Counseling Services Consumer Handbook, which contains information about the following topics. My initials and signature below indicates that I received a copy of the Handbook, and I understand the information:

_______________Consumer Rights & Responsibilities

_______________Limits of Confidentiality

_______________Notice of Privacy Practices/HIPAA

Please specify any contact restrictions: (i.e. call cell phone only, no message on answering machine)

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Permission is hereby given to the staff of The Next Step Counseling Services to provide treatment and/or services for ____.

I understand that I may choose to terminate treatment/services at any time.

____ __________________________

Consumer/Guardian Signature/Relationship Date

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Printed Name

____ __________________________

Witness Signature Date