HIPPA Act Information

** indicates a required field*

Consent for purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information (PHI) by In His Hands Counseling Center's counselors for the purpose of diagnosing or providing treatment to me, obtaining payment of my health care bills or to conduct health care operations of In His Hands Counseling Center. I understand that diagnosis or treatment of me by In His Hands Counseling Center's counselors may be conditioned upon my consent as evidenced by my eSignature on this document.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. In His Hands Counseling Center is not required to agree to the restrictions that I may request. However, if In His Hands Counseling Center's counselor agrees to a restriction that I request, the restriction is binding on client's specific In His Hands Counseling Center's counselor.

I have the right to revoke this consent, in writing, at any time, except to the extent that In His Hands Counseling Center has taken action in reliance on this consent.

My "PHI" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review In His Hands Counseling Center's Notice of Privacy Practices prior to signing this document. In His Hands Counseling Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations in In His Hands Counseling Center's practice.

In His Hands Counseling Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy by sent in the mail or asking for one at the time of my next appointment.

* **eSignature of Client or Personal Representative** ______________________

I consent to sharing information provided here.

Date:

Description of Personal Representative's Authority