MARYBETH HRIM, LCSW
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## Patient Health Information Consent Form

***I am here to inform you how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before I begin any therapeutic services I must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of these policies and procedures concerning the privacy of your Patient Health Information I encourage you to read the HIPAA NOTICE that is available to you before signing this consent.***

1. Client understands and agrees to allow this office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, and coordination of care. As an example, the client agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to me by the client for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The client has the right to examine and obtain a copy of his or her own records at any time and request corrections. Psychotherapy contact notes are not available for the client to review. The client may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. I am obligated to agree to those restrictions only to the extent they coincide with state and federal law.

3. A client's written consent need only be obtained one time for all subsequent care given to the client in this office.

4. The client may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. Our office may contact you periodically regarding appointments, treatments, services, performed by our office. You may choose to opt-out of any communications at any time.

6. For your security and right to privacy, I have been trained in the area of patient record Privacy. I take all precautions to assure that your records are never readily available to those who do not need them.

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7. Clients have the right to file a formal complaint Florida Board of Health about any possible violations of these policies and procedures without retaliation by this office.

8. This office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.

9. This notice is effective on the date stated below. You may revoke that permission, in writing, at any time.

10. If the client refuses to sign this consent for the purpose of treatment, payment and, the therapist has the right to refuse to give care.

***I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures***.

_____ _____

**NAME** **DATE**

_____

**SIGNATURE**