PITTSBURGH PASTORAL INSTITUTE

6324 Marchand Street
Pittsburgh, PA 15206

CONSENT TO TREATMENT

Client Name _____ Date of Birth _____/_____/_____

I have received a copy of my *Rights and Responsibilities* as a client of Pittsburgh Pastoral Institute (PPI). This includes information about the nature of pastoral counseling, as well as guidelines for an effective counseling process. I also have received a copy of PPI's *Notice of Privacy Practices*, which explains the ways in which confidential medical information may be used, disclosed, or accessed according to federal law and as contained in the *Health Insurance Portability and Accountability Act* (HIPAA), effective April 14, 2003. I understand that it is my right to read these documents before signing this form, and that I am entitled to a copy of this and any other consent form that I sign.

I am aware that communication with my counselor is noted and kept in a confidential file. I understand that, unless I authorize and sign a *release of information* form, it is PPI's policy to safeguard any information it gathers about me, as well as the medical records it compiles, from anyone who is not directly involved in my treatment. I further understand that, in cases of couple or family counseling, all participants over the age of 18 must authorize this release.

I understand that HIPAA mandates some exceptions to absolute confidentiality. These include:

1. PPI's right to use or disclose any medical information that may be required for purposes of carrying out treatment and related healthcare operations, and for obtaining payment for services.

2. The requirement that PPI counselors share with the proper authorities: reports or evidence of child abuse; reports or actions of suicidal or homicidal intent; and situations of life-threatening medical emergency. In such instances, my consent is not required.

I understand that I may request additional restrictions, beyond those stipulated in HIPAA, on the use and disclosure of my medical information, and that, while not required to agree to such requests, PPI will cooperate as far as possible. Where there is agreement, however, the restrictions will be binding on PPI.

I understand that, although my file is the property of PPI, I have a right to review and discuss the information in it, or to obtain a copy or summary of it at a reasonable charge.

I am aware that my counseling relationship with PPI will not deprive me of any civil rights, nor will I be discriminated against by PPI.

Over

I have been informed of my counseling fee and of the payment schedule.

By signing below, I consent to treatment and acknowledge that PPI and its counselors, physicians, employees, or agents may use or disclose my medical information as deemed appropriate (and according to state and federal law) to carry out treatment and related health-care operations, and to obtain payment for services.

_____ _____

Signature of Client or Legal Representative Date

If you are a legal representative, please check the basis for your authority:

- Custodial Parent
- Guardianship Order (attach copy)
- Power of Attorney (attach copy)

_____ _____

Counselor Signature Date