

Aloha Counselors, LLC

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, when we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices (NPP), which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you if you are using insurance. Private pay clients are not required to sign this. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.AlohaCounselor.com, or by calling us at 860.306.6118.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to Laura E. Williams. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

By signing below your consent to allow us to disclose your PHI, and you have been provided a copy of the notice of privacy practices from the website www.AlohaCounselors.com.

Signature of client or his or her personal representative

_____ I took a copy of NPP: yes ____ no ____
Date

Printed name of client or personal representative

Relationship to the client if not self

Description of personal representative's authority (e.g. mother)

Signature of authorized representative of this office or practice

Date of NPP: _____

Copy given to the client/parent/personal representative