northwinds
counseling services, p.a.

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Consent to Use Disclosure of Healthcare Information for Treatment, Payment or Healthcare Operations

This notice describes how Psychological and Medical information about you may be used and disclosed. Please review it carefully.

By signing this statement, I understand that as a part of my health care, Northwinds Counseling Services originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. This information could serve as:

- A basis for planning my care and treatment
- A means of communication among authorized health professionals who contribute to my care
- A source for applying my diagnosis information when filing a claim to my insurance
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Informed Consent for Confidentiality

1. If anyone requests information about me, my therapist will not give it unless and until I have signed a separate written authorization for her/him to do so. My therapist will not discuss anything about me with anyone without my written permission, except as noted here:
    A. If I use insurance benefits, my therapist and Northwinds Counseling cannot guarantee confidentiality from the insurance company.
    B. If my therapist learns that I have abused a child, a spouse, or vulnerable adult (or if I am a child, spouse, or vulnerable adult and report having been recently abused), she/he must report it to the proper authority.
    C. If my therapist has good reason to believe that I intend to physically harm myself or someone else, she/he will discuss it with me and may be required to warn that person or persons (the Tarasoff duty), or to take steps to prevent such harm by notifying the authorities.
    D. If my therapist has good reason to believe that I may be a danger to myself, she/he will contact at least one concerned person and/or take steps to prevent such harm by notifying the authorities.
    E. If I give permission to release my records to a legal representative of my choice, these records could become discoverable by other legal representatives. If subpoenaed by the courts to release your records, we may have to do so.
    F. My therapist may discuss my case with Northwinds clinicians and/or other outside professional case consultation groups. Identifying information (such as full name) will not be shared without written permission.
    G. Northwinds Counseling is in compliance with the State Department of Human Services which has the right to review all cases. DHS must abide by all rules of confidentiality.
2. All non-emancipated minor clients under the age of 18 years old must have the consent of their parent(s)/guardian following an initial intake session to receive further treatment services. Exceptions to this rule are when a minor is seeking services related to pregnancy, venereal disease or substance abuse.

I understand that as part of Northwinds Counseling Services' 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 understand and have been provided with a *Notice of Information Practices* that provides a more complete description of all information uses and disclosures. I fully understand and accept the terms listed in that document including my rights and privileges as a client of Northwinds Counseling Services.

_____ / _____Client's
Signature Legal Guardian /Relation to Client Date