Abella Counseling, LLC

HIPPA Privacy Policy

Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations.

I understand and consent that as a part of my health-care,

Print Client Name: _____ *Date of Birth:*____/_____/_____

Abella Counseling, LLC may receive, originate, maintain, disclose and use individually identifiable health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, billing and health insurance information. I understand and consent that Abella Counseling, LLC may use this information for the following:

- Diagnose my medical/psychiatric/psychological condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for the appropriateness of; and the quality of care provided) and peer reviews (the process of monitoring the effectiveness of health care personnel).

I acknowledge that I have been provided a Notice of Information Practices that fully explains the uses and disclosures that Abella Counseling, LLC will make with respect to my individually identifiable health information. I understand that I have the right to review said notice before signing this consent. I also understand that Abella Counseling, LLC reserves the right to change the notice and the practices detailed therein prospectively, and will notify me of any changes by sending a copy of the revised notice to the address I have provided or by providing a copy at my next office visit.

I understand I do not have to consent to the uses or disclosure of my individually identifiable health information for treatment, payment, and health-care services, but if I do not consent, Abella Counseling, LLC may refuse to provide health-care service to me unless applicable state or federal law requires Abella Counseling, LLC to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health-care operations. I further understand Abella Counseling, LLC is not required to agree to the requested restriction but, if it does agree, it must honor the restriction unless I request it stop doing so or Abella Counseling, LLC notifies me that it is no longer going to honor the request. I also understand I have the right to object to the use and/or disclosure of my individually identifiable health information for facility directories and to family members.

List any restrictions or objections to use: _____

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I understand that I may revoke this consent in writing, but that the revocation will not be effective to the extent Abella Counseling, LLC has already taken action in reliance on my earlier effective consent.

Client Name Printed	Client Signature	Date
Guardian Name Printed *if appropriate*	Guardian Signature *if appropriate*	Date