HIPAA Disclosure and Receipt of Privacy Practices

Client ________________________ **Date of Birth** ________________________

Printed name of client or legal representative ________________________ **Legal relationship to the client** ________________________

Authorization to Use and Disclose Individually Identifiable Health Information

I give permission to Madison Youth and Family Services, which shall include any and all of its officers, members, employees, agents, or representatives while acting on behalf of Madison Youth and Family Services (hereinafter collectively referred to as "MY&FS"), to use and/or disclose the following protected health information (hereinafter "PHI") as that term is defined in the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA"): Medical records; Treatment records; Diagnostic records; MY&FS Billing records; Psychotherapy notes; Demographic Data. I understand and acknowledge that the purposes of using or disclosing the above PHI include, but are not limited to: (1) providing me with medical care; (2) coordinating my medical care among and between medical professionals; (3) seeking and receiving payment from me, my insurance provider or a third party for the treatment and services I receive at MY&FS; (4) conducting health care operations; (5) providing me with appointment reminders; (6) suggesting or recommending potential treatment options or alternatives to me; (7) informing me of health-related benefits and services which may be available to me; and/or (8) complying with local, state or federal law. I understand and acknowledge that use and/or disclosure may be made on behalf of MY&FS by any of its officers, members, employees, agents, or representatives while acting on its behalf to entities such as insurance carriers, schools, family members, other mental health professionals or medical doctors, government and state agencies. A separate signed release of information is required in most cases to specify the intended recipient of your PHI, and the intended use/limits of that information, except where MY&FS may be mandated to report information without specific consent.

I understand and acknowledge that MY&FS will make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure or request, to the extent required by HIPAA. By executing this authorization, I expressly acknowledge that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under HIPAA. I understand and acknowledge that MY&FS will not condition treatment, payment, enrollment or eligibility for benefits on my execution of this authorization. I understand and acknowledge that I have a right to inspect and copy my PHI. I understand and acknowledge that I have a right to refuse to execute this authorization. I understand and acknowledge that such use or disclosure may result in remuneration to MY&FS. I understand and acknowledge that I have the right to revoke this authorization in writing at any time, except to the extent that MY&FS has taken action in reliance thereon. In order to revoke this authorization, I understand and acknowledge that I must send written notification expressly stating that I am revoking my authorization to use or disclose individually identifiable health information to the Assistant Director, Clinical Services of MY&FS at 10 School Street, Madison, CT 06443. I understand and acknowledge that this authorization expires one year from the later of: (1) the last day MY&FS provides or renders treatment to me; or (2) the day MY&FS receives any and all payments for services rendered by it to me, whether such payments are made by me, my insurance provider, or a third party. By executing this authorization, I acknowledge that I will be provided a copy of the same by MY&FS. If at any time I lose my copy, I understand and acknowledge that I may request a copy by contacting the assigned clinician and a copy will thereafter be provided to me.

***Signature of client or legal representative** ________________________ **Date**____________

Acknowledgment of receipt for MY&FS Privacy Practices:

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF MY&FS'S NOTICE OF PRIVACY PRACTICES AND I AM AWARE I MAY RECEIVE ANOTHER COPY AT ANY TIME I REQUEST, AND/OR VIEW THE DOCUMENT BY VISITING THE WEBSITE AT WWW.MADISONYOUTHSERVICES.COM.

***Signature of client or legal representative** ________________________ **Date**____________

Staff Signature ________________________ Date____________