Awareness Counseling Center
100 Katelyn Circle, Suite B
Warner Robins, GA 31088

Patient Information

Patient Consent for Use and Disclosure of Health Information

I hereby give my consent for my therapist and office staff to use and disclose protected health information about me to carry out treatment, payment, and health care operations. (The Notice of Privacy Practices provided by my therapist describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. My therapist reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to my therapist at the address listed above.

With this consent, my therapist and office staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including test results, among others.

With this consent, my therapist and office staff may mail to my home or other alternative location any items that assist the practice in carrying out health care operations, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent, my therapist and office staff may email to my home or other alternative location any items that assist in carrying out health care operations, such as appointment reminders and patient statements.

I have the right to request that my therapist and office staff restrict how it uses or discloses my personal health information to carry out health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow my therapist and office staff to use and disclose my personal health information to carry out health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, my therapist may decline to provide treatment to me.

Signed by: _

____
(Patient or Legal Guardian)

Date: ______________________

Relationship to Patient: ____