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Consent to Use and Disclose Your Health Information

This form is an agreement between you, ______________________________ and me, Monica A. Starr, APRN, LLC.

When I examine, diagnose, treat or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide what treatment is best for you and to subsequently provide treatment for you. I may also share this information with others who provide treatment to you, those who I collaborate with in order to provide better care for you, or to arrange payment for your treatment. The law permits me to disclose your health information without a signed authorization from you when I am using it to provide you health care. If I refer you to other health care professionals, I may need to tell them some things about you. I will get back their findings and opinions, and those will go in your records here. If you receive treatment in the future from other professionals, I can also share your health information with them. I will share only the minimum amount necessary in order to provide treatment to you.

Information you share with me will be kept strictly confidential other than for the reasons stated above and will not be disclosed without your written consent. If you or I want to use your information for any purpose besides those described above, I need your permission on an authorization form. By law, however, confidentiality is not guaranteed in life-threatening situations involving yourself or others, or in situations in which children are put at risk (such as by sexual or physical abuse or neglect). I can share some information about you with your family or others with your permission if we determine this to be helpful to your care. I will ask you first and will honor your wishes, as long as they fall within legal guidelines.

You have the right to request a copy of the progress notes or outpatient treatment reports that I maintain about you. However, psychotherapy process notes may not be reviewed and copied if I determine that this may cause harm to you or to others or would have a detrimental effect on your treatment, on our professional relationship, or on your records. In the future I may change how I use and share your information and may change this consent. If I do change it, I will give you a copy.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wishes.

By signing this form you are agreeing to let me use your information and send it to others for the purposes cited above. If you do not sign this consent form, I cannot treat you. After you have signed this consent, you have the right to revoke it (by writing a letter informing me that you no longer consent) and I will comply with your wishes about using or sharing your information from that time on, but I may already have used or shared some of your information and cannot change that. I will give you a copy of this form after you sign it.

Signature of Client: ____Date: _____________

If you have a problem with the way your health information has been handled, or if you believe your privacy rights have been violated, you have the right to file a complaint with me and with the Secretary of the Department of Health and Human Services. I promise that I will not in any way limit your care here or take any actions against you if you complain.

This notice is effective as of June 1, 2014.