FAMILY CONNECTIONS, LLC

Supporting Opportunities for Growth & Development

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

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CLIENT'S NAME

This consent form may be used only for/by Family Connections, LLC. Any other use makes this consent invalid.

I consent to the use or disclosure of my protected health information by Family Connections, LLC for the purpose of providing services to me, obtaining payment for bills or services I receive, or to conduct mental health care operations.

My protected health information means health information, including information that identifies me, that I have provided. It also means information that services providers have created about me and information that has been shared about me. This protected health information includes my past, present or future health of conditions or services. It includes information that could be used to identify me even if my name is not used.

I understand that toxicology testing, via mouth swabs, will be a component of my substance abuse counseling with Family Connections, LLC. I understand that all toxicology reports, including results, will be a permanent part of my clinician record. I understand that all signed releases will give the identified provided access to said toxicology results.

I have been provided a copy of the Notice of Privacy practices. I understand that I have a right to review the notice before signing this form. I understand that Family Connections, LLC can change the notice and their privacy practices. I can get a copy of the change notice by contacting Rebecca Carter, M.Ed, LMHC or Kelly Waldron, MA, CAGS, LMHC.

I understand that I have a right to ask for restrictions on how my protected health information is used. I understand Family Connections, LLC does not have to agree with the restrictions I ask for.

_____

Signature Date

_____

Signature of Personal Representative (if necessary) Date

_____

Witness Date

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