// CHRISTIAN COUNSELING ASSOCIATES, INC.
9650 Santiago Road Suite 101, Columbia, MD 21045
(410) 995-5587 and Fax (410) 992-1779

Patient Consent for Use and Disclosure of Protected Health Information

This form describes patient rights concerning protected health information under the law. Christian Counseling Associates, Inc (CCA) may use and disclose protected health information about you to provide treatment, to obtain payment and to carry out healthcare operations. You understand that CCA's Notice of Privacy Practices is posted in CCA's office and a copy of the document is available upon request. CCA reserves the right to revise its Notice of Privacy Practices at any time.

Consent to be Contacted by Christian Counseling Associates, Inc

CCA contacts patients regarding such matters as appointment reminders, payment, insurance issues, and issues pertaining to clinical care. Please indicate where we can contact you and if we can leave a message:

___________________ Cell phone ______ Can contact ______ Can leave message ______ DO NOT USE

___________________ Home phone ______ Can contact ______ Can leave message ______ DO NOT USE

____________________Work phone ______ Can contact ______ Can leave message ______ DO NOT USE

____ Email _______ Can contact

Authorization to Release Protected Health Information

If you authorize CCA to disclose information about you to others, please indicate the type of information we can release and with whom we can share this information:

______ Appointment Information _____Medical Information/Records ______Financial Information

Person or Entity to Receive the Information: ____
i.e. family members. For a minor we need parent or guardians here.

You understand that your therapist may have a supervisory arrangement due to quality assurance. You are authorizing your counselor to release any and all information related to your therapy to their supervisor, if applicable. You understand that this supervisor/ supervisee arrangement maintains a high standard of confidentiality.

CCA's staff will operate within ethical guidelines regarding confidentiality of records concerning your treatment but might be required by law to release any information regarding child neglect or abuse, or any threat to someone's life or well-being. Once you release any information to an insurance company, care management company, or doctor, CCA cannot assure confidential treatment of that information. You understand that you may request a restriction on the use or disclosure of your information, but that the staff of Christian Counseling Associates might not agree to such restriction on its use or disclosure. You understand that you have the right to revoke this consent, in writing to the address above. However, such revocation will not be retroactive. If you do revoke your consent Christian Counseling Associates can decline to provide treatment to you.

________________ ____
Date Signature of Client (or of Client's parent/ guardian)

Name of Client: ____

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COORDINATION OF CARE

To all clients who plan to use their insurance coverage, a signed copy of this document must be included in your file.

Your insurance company has requested that we communicate with your Primary Care Physician (PCP) or other health providers about your treatment. Your PCP is responsible for taking care of you as a whole person and therefore it is important for your PCP to be aware of any other types of care that you are receiving which could affect your overall personal health. At the same time, please be aware that we cannot release information about you to your PCP, except in the case of emergencies, without your consent.

CLIENT'S INSTRUCTIONS REGARDING RELEASE OF CONFIDENTIAL INFORMATION
To Primary Care Physician or other Ancillary Care Provider

Client Name ____ Name of Physician ____

Client SS# ____________________________________ Physician Address ____

Client Date of Birth ___________________________ ____

Physician Phone # ____________________________ Physician FAX # ____

I understand that the staff of Christian Counseling Associates, Inc., will keep all information about my mental health treatment confidential to the best of its ability, but cannot guarantee its security once the information leaves CCA's office. I understand that I am entitled to a copy of this authorization form for my records.

Permission to release information about my mental health and/or substance abuse treatment to the physician listed above in order to facilitate coordination of care is: *(Please initial the appropriate line)*

____________ Authorized * ____________ Withheld

This authorization becomes effective on the date listed below, and may be revoked by me in writing at any time, except to the extent of action already taken. Unless earlier revoked by me, this authorization automatically terminates the earlier of either one year from the effective date, or the term of coverage of my health insurance benefit plan. If I am signing for a minor child, I affirm that I am the parent or legal guardian of this minor client.

Signature ____ **Date** ________________

Printed Name ____

***If you authorize CCA to release information, then a copy of this form will be mailed to the physician named above with the following box filled in:**

Dear Primary Care Physician:

The above-named person was seen for an initial appointment by ____, of our staff. His/Her presenting diagnosis is ICD-10: __________, ____ .

He/She _____has _____has not scheduled an appointment for continued treatment of this disorder. Please feel free to contact the above-mentioned therapist for further information or to discuss treatment recommendations.