FAR WEST FAMILY SERVICES

Employee Assistance Program

CONSENT FORM

Authorization to Use and Disclose Protected Health Information

This form is an agreement between: (Client) ____
(Client/parent) ____ and (Far West Contract Therapist)
____. When we use the word "you" below, it will mean you and your child, family member, or other person if you have written his or her name on the line above. When the word "we" is used it will mean the contract therapist named on this form and the agency, Far West Family Services.

As we provide counseling services to you or refer you to other resources, we will collect what the law calls *Protected Health Information* (PHI) about you. We need to use this information to decide what treatment is best for you and how to provide treatment to you. We may share this information with others who provide treatment to you.

By signing this form, you are agreeing to let us use your information here and, with additional authorization, send to it others for treatment purposes. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form. Because we are committed to protecting your privacy, Far West Family Services will go above and beyond the PHI laws in most cases and obtain your specific consent prior to releasing information outside of the agency. Information will never be provided to your employer without your written permission. The only possible exception to the previous statement is if you present a serious threat of harm to yourself or others.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot legally treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website, **www.farwestfamilyservices.com,** or from our privacy officer, Diana Nielsen, at 206-682-8149.

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

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes for using or sharing your information from that time on. However, we may already have used or shared some of your information and cannot reverse that.

Your signature below indicates that you have received Far West Family Services' Notice of Privacy Practices form and that we have answered any questions you may have had about the form.

____ ______________________
Signature of client (age 13 and above) or parent/guardian Date

____ ______________________
Signature of client or parent/guardian (for child 17 and younger) Date

____ ______________________
Printed name of parent/guardian Relationship to client

DISTRIBUTION: WHITE COPY-COUNSELOR • PINK COPY- FW OFFICE • YELLOW COPY-CLIENT

Return this form to: Far West Family Services
PO Box 3271 • Edmonds, WA 98020 • 206-682-8149 • 1-800-398-3440 • Fax 425-582-8748