

FAR WEST FAMILY SERVICES

Employee Assistance Program

CONSENT FORM FOR COUNSELING

Authorization to Use and Disclose Protected Health Information

This form is an agreement between: (Client) _____
and (Far West Contract Therapist) _____ for counseling. When we use the word "you" below, it will mean you, your child, a family member, or other person whose name is written 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 on the next page explains in more detail your rights and how we may use and share your information. Please read it 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 may 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 that information for treatment or administrative purposes. You will have to tell us in writing what you want. 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 form, 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 the 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

Printed name of parent/guardian

Relationship to client

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you may get access to this information. Please review it carefully. Protecting the privacy of your personal health information is very important to us. When you see a Far West Family Services therapist, you will be given a copy of our privacy practices.

It is our right to change our privacy practices as long as law permits the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices, and the new terms of our notice, effective for all health information maintained, created, or received by us after the date the changes were made.

You may request a copy of our current Privacy Practices at any time by contacting our privacy officer. Contact information for us can be found at the end of this notice.

Typical Uses and Disclosures of Health Information

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may share your health care information with other health care professionals who provide treatment or other health services to you. These professionals will have a privacy and confidentiality policy like this one. If you request in writing that we do so, health information about you may also be disclosed to your family, friends, or other persons you choose to involve in your care.

Payment: Far West Family Services is a free service provided as a part of your employee benefit package, and there will never be a need to disclose personal health information in order to receive payment for Far West services.

Emergencies: In case of an emergency we may use or disclose your health information to notify or assist in the notification of a family member or another person responsible for your care, regarding your care, your location, your general condition, or your risk of death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions, or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care.

Health Care Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, the executive director, and the clinical supervisor. In most cases, this type of disclosure will be minimal and whenever possible, clinical supervision will be done without the disclosure of any identifying information by the therapist.

Required by Law: We may use or disclose your health information when we are required to do so by law, e.g., by court or administrative order, subpoena, or other lawful process. We will use and disclose your information when requested by national security, or intelligence officials, and other state and federal officials, or if you are an inmate or otherwise under the custody of law enforcement officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including but not limited to emails or texts.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you may do so by sending us a letter to the address at the end of this notice. Once approved, an appointment can be made to review your records. You may be charged a fee for copies of your records. If you prefer a summary or an explanation of your health information, we will provide one without a fee. Please contact our privacy officer for an Authorization to Release Information form.

Amendment: You have the right to amend your health care information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances your request may be denied.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement except in emergencies. Please contact our privacy officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Questions and Complaints: You have the right to file a complaint with us if you feel we have not complied with our privacy policies. Your complaint should be directed to our privacy officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you may complain to us in writing. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US REGARDING PRIVACY ISSUES:

Privacy Officer:

Diana Nielsen
Business Manager
PO Box 3271
Edmonds, WA 98020
206-682-8149 or 1-800-398-3440
diana.nielsen@comcast.net