gateways counseling & consulting center

care • compassion • competence

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and Gateways Counseling and Consulting Center. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

_____

When we examine, test, diagnose, treat or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use you PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share our information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change, you can get a copy by calling us at 541-942-0040, or from our privacy officer, Diana Knee.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, 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 accept these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI. If we have already used or shared some of your PHI, we cannot change that.

_____ _____

Signature of Client Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____ _____

Description of personal representative's authority

_____

Signature of authorized representative of this office or practice

Copy given to the client/parent/personal representative Date of NPP:_____

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The Rights of Clients

1. You have the right to decide not to enter therapy with me. If you wish, I will provide you with the names of other good therapists.

2. You have the right to end therapy at any time. The only thing you will have to do is to pay for any treatments you have already had.

3. You have the right to ask any questions, at any time, about what we do during therapy, and to receive answers that satisfy you. If you wish, I will explain my usual methods to you.

4. You have the right not to allow the use of any therapy technique. If I plan to use any unusual technique, I will tell you and discuss its benefits and risks.

5. You have the right to keep what you tell me private. Generally, no one will learn of our work without your written permission. There are some situations in which I am required by law to reveal some of the things you tell me, even without your permission, and if I do reveal these things I am not required by the law to tell you that I have done so. Here are some of these situations:

    - If you seriously threaten to harm another person, I musts warn that person and the authorities.
    - If a court orders me to testify about you, I must do so.
    - If I am testing or treating you under a court order, I must report my findings to the court.

6. If I wish to record a session, I will get your informed consent in writing. You have the right to prevent any such recording.

7. You have the right to review your records in my files at any time, to add to or correct them, and to get copies for other professionals to use.