New Beginnings Family Counseling Services

911 E. Jefferson St. Charlottesville, Va 22902 Phone: (434)984-0023

Protected Health Information - HIPAA

Protected Health Information - HIPAA

I consent to the use or disclosure of my protected health information by the New Beginnings Family Counseling Services, Inc. (NB) for the purposes of treatment, payment and health care operations. I understand that the privacy of my health information is protected by state and federal law. I acknowledge my right to review the NB Notice of Privacy Practices and affirm that I have received or been offered a copy of the Notice of Privacy Pracöces.

NB reserves the right to change the terms of its Notice of Privacy Practices for protected health information at any time. If NB does change the terms of its Notice of Privacy Practice, a general notice will be posted within seven calendar days of the chang in the waiting area and business office. I may obtain a copy of the revised notice by submitting a written request to the NB Office Manager, 911 East Jefferson Street, Charlottesville, VA 22902 or by calling (434) 984-0023.

I retain the right to request that NB restrict how my protected health information is used or disclosed to carry out treatment and payment operations. I understand that NB is not required to agree to such requested restrictions; however, if NB does agree to my requested restriction(s). such restriction(s) are then binding upon NB.

At all times, I understand that I retain the right to revoke this Consent. Such revocation must be submitted in writing to the NB Compliance Officer (at address listed above). The revocation will become effective immediately upon receipt of my notice except to the extent that NB has already taken action based on this Consent.

NB may refuse to treat or serve me if I (or my authorized representative) do not sign this Consent form (except to the extent that NB is required by law to treat individu?ls). If I (or my authorized representative) sign this Consent form and then revoke my consent, NB has the right to refuse to provide further treatment or services to me as of the date and time NB receives rnv notice or revocation (except to the extent that NB is required by law to treat individuals).

I affirm that have read and understand this information and that I have received or been offered a copy of the Notice of Privacy Practices. also acknowledge that I have had the opportunity to ask questions, and understand that I may request further explanation of its terms and conditions at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print your full name) (Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Witness) (Signature of Authorized Representative- Legal Guardian)

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_