

ISLAND THERAPY SOLUTIONS
CONSENT FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION TO CARRY OUT
TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Client Name: _____ Date of Birth: ____ / ____ / ____
(Last) (First) (Middle)

Home Address: _____

I understand that any of my personal health information (other than notes from any therapy sessions with a counselor) may be used and/or disclosed by Island Therapy Solutions for purposes of carrying out treatment, obtaining payment, and carrying out other health care operations of the organization. I have received a copy of Island Therapy Solutions' Notice of Privacy Practices, which I understand provides a more complete description of possible uses and disclosures of my health information. I understand that it is my right to review the Notice of Privacy Practices prior to signing this consent form. I also understand that the terms of the Notice of Privacy Practices may change in the future and that I may obtain a copy of the Notice of Privacy Practices that is in effect at any given time (whether or not it has ever been changed) by requesting a copy at the front desk.

I understand that I have a right to request how my health information is used or disclosed to carry out treatment, payment or other health care operations, but I also know that Island Therapy Solutions is not required to agree to any such request. I understand that, if Island Therapy Solutions agrees to my request, the restriction will be binding on Island Therapy Solutions.

I understand that I have a right to revoke this consent by filling out and signing a written revocation form which is available at the front desk, from the Office Manager. I also understand that, if I choose to revoke my consent, it can only be revoked to the extent that Island Therapy Solutions has not acted in reliance upon the consent.

By signing below, I hereby voluntarily and knowingly consent to allow Island Therapy Solutions and any of its physicians, counselors, employees and/or agents, to use and/or disclose my health information as deemed appropriate to carry out treatment, payment and/or other health care operations of the organization.

Dated: _____
(Signature of Client or Legal Representative)

If you are the legal representative of the client, please check off the basis for your authority:

- Power of Attorney (attach copy)
- Guardianship Order (attach copy)
- Parent of Minor
- Other _____