Children's Aid and Family Services, Inc.

CONSENT FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS
(BEHAVIORAL SERVICES PROVIDERS)

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 Children's Aid and Family Services, Inc. (CAFS) for purposes of carrying out treatment, obtaining payment, and carrying out other health care operations of the organization. I have received a copy of CAFS 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 from my counselor or case manager.

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

I understand that I have a right to revoke this consent by filling out and signing a written revocation form, which is available from my counselor or case manager. I also understand that, if I choose to revoke my consent, it can only be revoked to the extent that CAFS has not acted in reliance upon the consent.

By signing below, I hereby voluntarily and knowingly consent to allow CAFS 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) ☐ Other________________________
- ☐ Guardianship Order (attach copy)
- ☐ Parent of Minor

For Office Use Only
Client ID No.______________
Case Manager_____________
Clinician ________________