CAROL MILES MSW, LCSW

Consent For the Use of and Disclosure of Protected Health Information for Treatment, Payment and Healthcare Operations

To be used only when Carol Miles MSW, LCSW is filing with your insurance

I understand that part of my healthcare involves this clinician's creation of records known as a medical chart or clinical record that contains my symptoms, prior treatment, medical history, assessments and evaluation, test results, diagnoses, treatment recommendations and plans and plans or recommendations for any future treatment and records obtained from other medical or mental health professionals. This information is Protected Health Information.

I understand that as a condition to my receiving treatment from Carol Miles, MSW, LCSW at this office, I am consenting to: Carol Miles, MSW, LCSW using my personally identifiable mental health information for my evaluation and treatment; **to obtain authorization from the managed care company or PPO to access services or to obtain payment from my health plan**, and as necessary for the operations of this office. These uses and disclosures are more fully explained in the Privacy Practices Notice, which can be made available if requested.

I understand I have the right to request restrictions as to how this office uses or discloses my mental health information to carry out treatment, payment or healthcare operations. I understand that this office is not required to agree to the restrictions but if it does agree to the restrictions, it is bound to abide by them.

_____No restrictions requested

_____I request the following restriction to the use or disclosure of my health information:

_____

_____

I understand I have the right to revoke this consent in writing at any time, except to the extent that this office has taken action in reliance on it. I understand that the provision of future treatment may be withdrawn if I withdraw my consent. In the event that this does happen, my clinician will make every reasonable effort to refer me to alternative services.

_____ _____

Signature of Client or Authorized Agent **Date** **Witness** **Date**

MUST BE COMPLETED IF USING INSURANCE

Primary Insurance_____

Address_____

City_____State_____Zip_____Phone( ) _____

Insured's name _____ SS #:_____

Relationship to client_____

Group #:_____Policy #:_____

AUTHORIZATION NUMBER_____

Secondary Insurance_____Address_____

City_____State_____Zip_____Phone( )_____

Insured's name_____SS #:_____

Relationship to client_____

Group #:_____Policy #:_____