PRIVACY PRACTICES: ACKNOWLEDGEMENT AND CONSENT

I understand that the Children's Program holds health information about me. I understand that my health information may include information both created and received by the practice/facility, may be in the form of written or electronic records or spoken words, and may include information about my mental health/health history, mental health/health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of mental health/health-related information.

I understand and agree that the Children's Program may use and disclose my mental health/health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other mental health/health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my mental health/health care.
- Perform various office, administrative and business functions that support my practitioner/provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective mental health/health care.

I also understand that I have the right to receive and review a written description of how the Children's Program will handle mental health/health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of mental health/health information made and the information practices followed by the employees, staff, and other office personnel of the Children's Program, and my rights regarding my mental health/health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of the Children's Program's Notice of Privacy Practices in effect is available in written form at my request and posted on the website at www.childrensprogram.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that the Children's Program is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above.

Patient's Name: _____ Date of Birth: _____
please print

By: _____ DOB: _____ Date: _____
(Patient – age 14 years or older)

By: _____ Date: _____
(Patient's Representative)

Description of Representative: _____
(parent/guardian/legal representative)