HOOPER COUNSELING AND CONSULTATION SERVICES, LLC
Promoting Authenticity in Thinking, Doing, and Being
Connie Bussey-Hooper, LMSW, DCSW, Owner and Mental Health Therapist

CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Federal Standards requires Hooper Counseling and Consultation, LLC to inform you of its privacy practices before using or disclosing your protected health information to carry out treatment, payment or health care operations (45 CFR § 164.506). Your consent to Hooper Counseling and Consultation Services, LLC does not allow any other covered health care person or organization to use or disclose your protected health information.

You may revoke this consent in writing at any time, except to the extent that Hooper Counseling and Consultation Services, LLC has already acted on this consent.

Hooper Counseling and Consultation Services, LLC reserves the right to change its privacy practices. You have a right to ask your therapist to restrict how your protected health information is used or disclosed for treatment, payment or health care operations. Hooper Counseling and Consultation Services, LLC is not required to agree to every restriction you request. If your therapist does agree to a restriction, the restriction is binding on them.

We may refuse to release information to a 3rd party, even if a signed consent form is on file with either party, if it is determined by your individual therapist at to be detrimental to the progress of your treatment.

Please list any restrictions on uses or disclosures you are requesting:

I authorize Hooper Counseling and Consultation Services, LLC to disclose, release, or obtain to the following individuals, organizations, or parties, if necessary, my protected health information for treatment purposes:

_____No One _____Only the Following (Please initial choice)

Individual or Agency: _____

Address & Phone Number:_____

_____ This person has permission to only have information regarding and/or to make financial payments.

_____ This person has permission to only have information regarding and/or scheduling appointments.

This authorization will expire on:

Specific Date:_____ On Termination of Therapy:_____ Other:_____

_____

Signature of Client/Parent/Guardian Date

_____

Printed Name of Client or Guardian

Psychological and Behavioral Consultants
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