HIPAA Consent for Purposes of Treatment, Payment and Healthcare Operations

I understand that as part of my healthcare, Kennebec Behavioral Health originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many professionals who contribute to my care
- a source of information for applying my diagnosis to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my protected health information (PHI) is used or disclosed to carry out treatment, payment or healthcare operations. Kennebec Behavioral Health is not required to agree to the restrictions that I may request. However, if Kennebec Behavioral Health agrees to a restriction that I request, the restriction is binding. You may request restrictions to the use or disclosure of your PHI (other than the specific requests listed below) by contacting the Agency's Chief Privacy Officer at 873-2136 or 1-888-322-2136.

I have the right to revoke this consent, in writing, at any time, except to the extent that Kennebec Behavioral Health has taken action in reliance on this consent.

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Signature of Patient or Personal Representative (circle one)

_____ _____

Printed Name of Patient or Personal Representative | Description of Personal Representative's Authority

I understand I have a right to review the KBH'S Notice of Privacy Practices prior to signing this Consent. This Notice further details the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations.

Notice of Privacy Practices

Kennebec Behavioral Health's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices for the KBH is also posted in the waiting areas at each location and on the KBH's website at www.kbhmaine.org. This Notice of Privacy Practices describes my rights and Kennebec Behavioral Health's duties with respect to my protected health information including a statement that pertains to confidentiality of alcohol and drug abuse records maintained by our program and protected by Federal Law and Regulations (42 CFR Part 2).

Kennebec Behavioral Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Kennebec Behavioral Health's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

It is ☐ **okay** ☐ **not okay** to contact me for appointment reminders

It is ☐ **okay** ☐ **not okay** to identify as Kennebec Behavioral Health when contacting me by phone.

It is ☐ **okay** ☐ **not okay** to contact me for post-discharge client satisfaction surveys.

I have received a copy of KBH's Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative (circle one) | Description of Personal Representative's Authority

_____ _____ _____

Client Name | Medical Record # | Date