# *Aurora Family Counseling Center*

# PRIVACY CONSENT FORM

Consent for use/and or disclosure of health information to carry out treatment, payment and health care options.

I understand that any of my personal health information contained within designated record set may be used and/or disclosed by Aurora Family Counseling for purposes of carrying out treatment, obtaining payment, and carrying out other health care operations of the organization. For substance abuse information, payment information, payment information can only be obtained by those for whom a current authorization exists. I have received a copy of Aurora Family Counseling Center's Notice of Privacy Practices, which I understand provides a more completed 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 the consent form. I also understand the Notice of Privacy Practices may change in the future and that I may obtain a copy at any given time (whether or not it has been changed) by requesting a copy at the front desk or from Aurora Family Counseling staff/clinician.

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

I understand that I have the right to revoke this consent by filling out and signing a written statement revocation form that is available at the front desk or from Aurora Family Counseling staff/clinician. I also understand that if I choose to revoke my consent, it can only be revoked to the extent that Aurora Family Counseling has not acted to reliance upon the consent.

By signing below, I hereby voluntarily and knowingly consent to allow Aurora Family Counseling and any of its physicians, clinicians, employees, and/or agents, to use and/or disclose my health information as deemed appropriate to carry out treatment, payment and/or health care operations of the organization.

I have received a copy of the Notice of Privacy Practices

_____ _____

Client Signature or Legal Representative Date

_____ _____

Witness Signature Date

If you are a legal representative of the person listed above, please check off the basis for your authority:

_____ Power of Attorney _____ Guardianship Order (attach copy)

_____ Parent of Minor Other: _____

*Note (If there is a court ordered arrangement you must provide the most recent copy of the court order granting your legal custody of the minor child)

CLIENT NAME: _____ , _____ , _____ DOB ____/____/____

(LAST) (FIRST) (MIDDLE)