CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION PURPOSES

Client Name _____ Date of Birth_____

Client Medical Record #_____ Client SS #_____

I give my voluntary consent for Wright School and _____
Name of Agency/Agencies or Individual(s)
_____

to use and disclose health information regarding _____
(Client Name)

to and from the agencies/individuals specified above when applicable for purposes of treatment*, payment** (including benefit payment and for establishment of entitlements) and health care operations***: Social Security Administration, Civil Service, Medicaid, Medicare, Veterans Administration, Armed Services, State Employee Health Plan, Disability Determination Office, Railroad Retirement, Blue Cross/Blue Shield, any other health or benefit program for determination of coverage and for disclosure of information related to payment activities, this agency's Human Rights Committee, community agencies that may need to provide services to aid in my treatment or payment such as County Dept of Social Services, Vocational Rehabilitation, Area Agencies on Aging, and the health care providers that I am referred to or from for treatment purposes. I also consent for you to disclose information relevant to payment activities to the person responsible for payment of my bills (guarantor) if different from myself _____.
(Guarantor Name)

The information to be used and disclosed may include history and evaluations, test results, treatment plans, academic and behavioral progress reports, summaries, follow-up reports.

I understand that state and federal law permit certain uses and disclosures for treatment, payment and health care operations without my consent and these have been explained in the *Notice of Privacy Practices* that has been provided to me. I understand that the health information used and disclosed may include information related to the above-named client's HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing.

I understand this consent is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for payment purposes, wherein the consent is valid until the need for disclosure is satisfied. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this consent prior to the rescinded date is legal and binding.

A copy of this consent shall be considered as valid as the original.

_____	_____	_____
(Signature of Parent/Guardian)	*(Date)*	*(Relationship to Client/Authority)*

_____	_____
(Signature of Witness)	*(Date)*

(Staff Use Only)

NOTE: This Consent was revoked on _____ _____
(Date) *(Signature of Staff)*

DHHS-1010 (4/03)
Consent to Use and Disclose Health Information for Treatment, Payment, Health Operation Purposes

REVOCATION SECTION

I do hereby request that this consent to disclose health information of _____
(Name of Client)

signed by_____ on _____
(*Enter Name of Person Who Signed Consent)* *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this consent prior to the
(Date)

rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Parent/Guardian)	*(Date)*	*(Relationship to Client/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this consent by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any action
(Date)

taken on this consent prior to the rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Staff)	*(Date)*	*(Signature of Witness)*	*(Date)*

**Treatment* means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

***Payment* means to obtain or provide reimbursement for the provision of health care; determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing; review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services; and disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: Name and address; Date of birth; Social security number; Payment history; Account number; and Name and address of the health care provider and/or health plan.

****Health Care Operations* include conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and clients with information about treatment alternatives; related functions that do not include treatment; reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and business management and general administrative activities of the entity, including, but not limited to: Management activities relating to implementation of and compliance with the requirements of HIPAA; Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; Resolution of internal grievances; The sale, transfer, merger, or consolidation of all or part of a covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and Creating de- identified health information and fundraising for the benefit of the covered entity.