Consent To Use and Disclose Your Health Information

This form is an agreement between you, ________________________________ and NORTHLAND COUNSELING SERVICES. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here.
____

When we examine, test diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form.

If you do not sign this consent form, agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our office or by calling us at 715-373-0160, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

____ ___________________
Signature of client or his or her personal representative Date

____ ___________________
Printed name of client or personal representative Relationship to client

____
Description of personal representative's authority

____
Signature of authorized representative of this office or practice

Date of NPP ___________ ☐ Copy given to the client/parent/personal representative