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Consent to Use or Disclose Information for Treatment, Payment or Health Care Operations

Federal HIPPA regulations (the Health Insurance Portability and Accountability Act) allow therapists to use or disclose certain Protected Health Information (PHI) from your records, without your permission, in order to provide treatment to you, to obtain payment for the services provided, and for other professional activities (known as "Health Care Operations"). Nevertheless, I ask here for your written consent to these releases so that you may be fully aware of these processes. I will always seek to inform you in advance, and get your permission, any time any of your PHI may need to be disclosed for any reason. These disclosures are almost exclusively to insurance companies or other third-party reimbursers.

PHI (as defined by HIPPA) may include information about medications you may be taking, session times, therapy techniques we use, testing results (if any), and summaries of diagnoses, functional status, treatment plan, symptoms, prognosis and progress. PHI does NOT include any intimate personal details that may be shared in the course of therapy. Please see our Notice of Privacy Practices which describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent and you may revoke this consent at any time by giving written notification.

This consent is voluntary; you do not have to sign it. However, I may not be able to provide services if this consent is not granted, or if the consent is later revoked, and third parties (such as insurance companies) will probably not be willing to reimburse for services without disclosure of this information.

I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices/ HIPAA Notice.

Initial here: _____

I hereby consent to the use or disclosure of my PHI as specified above.

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____