Your Rights Regarding Your Health Information
Consent to Use and Disclose Your Health Information

This form is an agreement between you _____ and Richard L. Baum, Ed.D. The word 'you' in this context means you, your child, or any other person that you have guardianship of and that you have written their name in this space _____.

When we examine, diagnose, treat, or refer you we will be collecting **Protected Health Information** (PHI). We use this information to decide the best course of treatment. We also may share this information with others who provide treatment to you, arrange payment for the services or other business or governmental functions.

By signing this form you are agreeing to use and at times release your information. The Notice of Privacy Practices explains your rights in more detail. This is available in booklet form in the waiting room.

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

1. You can ask that we communicate with you about your health to protect your privacy. (Ex. Calling you only at home) We will do our best to honor your request
2. You have the right to ask us to limit what we tell people involved in your care or payment for your care, such as family members and friends. While we are not required to honor your request, if we do, we will keep our agreement except if it is against the law, an emergency, when the information is necessary to treat you or if there is a billing issue and your insurance company needs added information to reimburse for services we provided for you.
3. You have the right to inspect your health information that we possess. You can get a copy of all records, however, you may be charged for this service. Speak to Dr. Baum if there is a question.
4. If you believe that information in your record in your record is either incorrect or missing important information you can ask us to make changes (called amending record) to your health information. Please make this request in writing and include the reason(s) you believe the changes is necessary.
5. You have a right to a copy of this notice. If this changes, the new form will be available in the waiting area.
6. You have the right to file a complaint if you believe that your privacy rights have been violated. You can file a complaint with the office and the Secretary of the Department of Health and Human Services. All complaint must be in writing. Filing a complaint will not negatively affect our treatment of you.
7. You may also have other rights granted to you by the state Ohio. I will be happy to discuss these situations with you at any time.

_____ _____

Signature of client or representative if client is under 18 or not capable | Date

_____ _____

Print name | Relationship to the client

Client's Informed Consent

I have chosen to have treatment with Richard L. Baum, Ed. D. This choice is voluntary and I understand that I can terminate at any time.

I further understand that there is no assurance that I will feel better. Psychotherapy is a collaborative effort and I commit to work cooperatively with Dr. Baum.

I further understand that during the course of treatment, material may be discussed which could be upsetting in nature, but which may be necessary to help me resolve the issues that brought me to therapy.

I understand that my records will be held or released in accordance with releases I have signed in addition to state and federal laws regarding confidentiality of medical records.

I further understand that laws require that Dr. Baum report all cases in which there exists a danger to self or others as well as other circumstances where the law requires a release of my confidential information.

I understand that my insurance/managed care company to ensure continuity and quality of treatment and/or after the completion of treatment may contact Dr. Baum or me to assess its outcome.

1. I have read and understand the rights of those who undergo treatment with Dr. Baum. These include:
2. The right to be informed about the nature of the treatment
3. Right to confidentiality under all law related to receiving this type of treatment The right to humane and respectful care that is free from harm, abuse or neglect
4. The right to make an informed consent decision whether to accept or refuse treatment. The right to contract and solicit and select a psychologist of my own choice and at my own expense

If disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been render or information released in reliance of a previous consent. This release expires one year after the termination of treatment after al claims have been paid as provided in your benefit plan.

I have read and understood the above information

_____ _____

Client's signature Date

_____ _____

Client (Guardian) signature Date

Sharing Your Confidential Information

There are times when we agree that your confidential information should or could be shared another person. If you want, you can use this space to identify a person(s) that you would be willing to have us share information with. Remember you can revoke this in writing at any time.

You cannot retroactively revoke permission to release information.

Individuals who I have given permission to release information to:

Name(s)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____