Easttown Psychotherapy, L.L.C.

Wisconsin Mental Health Consent

Purpose: This form is to obtain an individual's written permission under Wisconsin law for our use of the individual's mental health treatment records to carry out treatment, payment activities, and health care operations, and our disclosure of the individual's mental health treatment records to family members or other persons involved in their care or payment for their care, and billing and assignment of benefits. This form should not be used to obtain written permission for the disclosure of mental health treatment records unless the name of the recipient is listed on this form.

Individual Giving Consent:

Name: ____
Last First Middle

Address: ____
Street City Zip

Phone: ____________________

Client Name (if different from above) ____________________

Client Date of Birth: ____________________

E-mail Address (used to send out appointment reminders): ____________________

To The Individual: Please read the following and complete the information requested.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

The uses and disclosures being authorized.

Our uses of mental health treatment records: By signing this form, you will consent to our use of your mental health treatment records to carry out treatment, payment activities, and health care operations as set forth in our privacy practices notice. This consent is effective until you revoke it in writing. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you if you revoke this consent.

Our communication with you.

Please check the boxes below to indicate your consent to the following:

We may send correspondence to your home.	( )Yes	( ) No
We may call you at home.	( )Yes	( ) No
We may leave a message on you answering machine or voicemail.	( ) Yes	( ) No
We may send e-mail appointment reminders	( ) Yes	( ) No

I had full opportunity to read and consider the contents of this consent. I understand that by signing this form, I am confirming my written permission for the use and disclosure of my mental health records as described in this form. I also confirm that I received a copy of the Privacy Practice Notice.

______________________________ ______________________________

Signature of self or legal guardian **Date**

Easttown Psychotherapy, L.L.C.

Privacy Practices Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Organizations Covered by this Notice

This notice applies to the privacy practices of Easttown Psychotherapy L.L.C. only.

Our Legal Duty

I am required by applicable law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect July 1, 2020 and will remain in effect unless we replace it.

We reserve that right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made changes. Before we make a significant change in our privacy practices, we will change this notice, post the revised notice at our service delivery site and make the new notice available to our patients and others upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

Nothing contained in this privacy practices notice shall be deemed or construed as a waiver of Easttown Psychotherapy, L.L.C.

Uses and Disclosures of Medical Information

Your authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Health related products and services: We may use your medical information to contact you to provide appointment reminders and to communicate with you about treatment alternatives and other health related benefits and services that may be of interest to you. These communications my describe health related products or services that we provide, payment for such products or services, and the health care providers in a provider or health plan network.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds or public health and interest activities, judicial and administrative proceedings, law enforcement, research, and other public benefit functions such as the following: for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence. To avert a serious and imminent threat to health or safety, for health care oversight, such as activities of state licensing and peer review authorities, and fraud prevention enforcement agencies, for research and in response to court and certain administrative orders and other lawful process. As well as to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies and identifying or locating suspects or other persons, to coroners, medical examiners, funeral directors. To military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding person in lawful custody and as authorized by worker's compensation laws. You may be able to opt out of use or disclosure of you medical information for research purposes or pursuant to be written request from a government agency, unless disclosure is required by law. We may not disclose HIV test results, certain confidential medical information or mental health treatment records for certain of these purposes without your written permission, unless required by law.

Individual rights

Access: You have the right to examine and to receive a copy of your medical information with limited exceptions. You must make a written request to obtain access to your medical information. You should submit you request to the contact at the end of this notice. We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you and for preparing any summary or explanation of you medical information you request. Contacting us using the information at the end of this notice for information about our fees.

Disclosure Accounting: You have the right to a list of instances after December 31 2021 in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you and for certain other activities. You also have the right to a list of all written disclosures of your mental health treatment records. You should submit your request to the contact at the end of this notice. We will provide you with information about each accounting disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more then 6 years before the date request. If you request this accounting more then once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to your additional requests.

Amendment: You have the right to request that we amend your medical information and mental health treatment records. Your request must be in writing, and it must explain why the information should be amended. You should submit you request to the contact at the end of this notice. We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restrictions: You have the right to request that we restrict our use or disclosure of you medical information for treatment, payment or health care operations, or with family, friends, or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit you request to the contact at the end of this notice. Any agreement we make to a request for restriction must be in writing signed by a person authorized to bind us to such an agreement.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations that you specify. You must make your request in writing. You should submit your request to the contact at the end of this notice. We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication, and explains how payment for our services will be handled under the alternative means or alternative location you request for confidential communication of your medical information. We will not ask you to explain the reason for your request.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information at the end of this notice.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this notice. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, in response to a request you made to amend, restrict the use or disclosure of or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the:

State Grievance Examiner

Division of Mental Health and Substance Abuse Services
Department of Health Services
1 West Wilson Street, Room 850
P.O. Box 7851
Madison, WI 53707-7851
1-608-266-9369

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