**Associates in Psychology & Therapy, Inc. (APT, Inc.)**



**East Hills Professional Center**

**5185 Route 60 East, Suite 32**

**Huntington, WV 25705**

**www.wvpsychologist.com**

**PH: (304) 302-0526 Fax: (304) 302-0527**

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| **Consent For Treatment, Confidentiality And Release Of Information** |

**Name:**  **Exam Date:**

**Date of Birth:**

**Consent for Health Care Services:** I authorize consent for mental health treatment at Associates in Psychology & Therapy, Inc. (APT, Inc.).

**Authorization for Release of Information:** Associates in Psychology & Therapy, Inc. (APT, Inc.) may release information from my medical records to any health care provider involved in my care and treatment. Associates in Psychology & Therapy, Inc. (APT, Inc.) may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of mental health record information to an insurance company or other payer pursuant to this authorization,Associates in Psychology & Therapy, Inc. (APT, Inc.) is no longer responsible for the confidentiality of any information known or possessed by the payer.

**Confidentiality and Treatment:** Your confidentiality will be carefully protected by us. However, you should be aware of specific situations under which we are required by law to break that confidentiality. These include:

* + 1. If you tell the clinician of your intent to harm yourself or others
    2. If you tell the clinician of your involvement in abuse of children or elderly persons.
    3. If a court order is issued requiring release of information.
    4. If you sign a request for release of information.

**I acknowledge that:**

* **I have read this form and understand its contents.**
* **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
* **I have received a copy of Associates in Psychology & Therapy, Inc. (APT, Inc.) HIPAA Policy.**

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Signature of Patient or Legally Responsible PersonName (Please print)

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Relationship/Reason Why Patient Is Unable to Sign Date