

Serving Children and Reaching Families, LLC  
1216 Patrick Street  
Kissimmee, Florida 34741  
Phone: 321-236-1540/ Fax: 321-594-6096

## Client Consent Form

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- I. I understand that the client's health information is private and confidential. I understand that Serving Children and Reaching Families work very hard to protect the client's privacy and preserve the confidentiality of the client's personal health information. I understand that Serving Children and Reaching Families may use and disclose the client's personal health information to help provide health care and services to the client, to handle billing and payment, and to take care of other health care operations and community-based services. I further understand that sometimes the law may require the release of this information without my permission. Examples would be if:
- A client has threatened to hurt someone
  - Abuse or neglect of a minor, disabled or elderly person is reported or suspected (all Serving Children and Reaching Families staff is legally required to report concerns to the Department of Children and Families.)
  - Serving Children and Reaching Families or staff testimony is subpoenaed by Court Order; we are required to produce records or appear in court to answer questions about the client.
- II. I understand that all information, including client assessment, treatment notes, etc. are treated with strict confidentiality and that no information, either verbal or written, will be shared without the written consent of legal guardian (if client is under the age of 18). I understand that individuals responsible for care through Serving Children and Reaching Families will need to have access to confidential information for the purpose of assessment and treatment coordination. By law, rules of confidentiality do not hold under the reasons listed above (see section I)
- III. I consent to coordination of care with client's Primary Care Physician when clinically appropriate. I also authorize the staff from Serving Children and Reaching Families to release monthly updates regarding medication changes to the Primary Care Physician for the purpose of continuity in care, if applicable. I consent to coordination of care, which may include sharing information verbally or in writing through psychotherapy notes related to my/my child's treatment with all Serving Children and Reaching Families Staff and Contract Staff and Funding Agencies when clinically appropriate.
- IV. I consent to treatment taking place at any of the following location(s), as agreed upon: (1) Home (2) School (3) Office
- V. I was given a copy of Serving Children and Reaching Families' Client Handbook, which details the agency's "Notice of Privacy Practices." It contains more information about the policies and practices protecting the client's privacy. I understand that I have the right to read the "Notice" before signing this agreement. I understand that Serving Children and Reaching Families may update this "Notice of Privacy Practices." If I ask, Serving Children and Reaching Families will provide me with the most current "Notice of Privacy Practices." Under the terms of this consent, I can ask Serving Children and Reaching Families to limit how the client's personal health information is used or disclosed to carry out treatment, payment or health care and services operations. I understand that Serving Children and Reaching Families do not have to agree to my request. If Serving Children and Reaching Families do agree to my request, I understand that Serving Children and Reaching Families would follow the agreed limits.

- VI. I understand that I have the right to revoke this consent. If I revoke this consent, Serving Children and Reaching Families do not have to provide any further health care services to the client. I may revoke this consent in writing at any time by doing one of the following:
- Signing and dating a form that Serving Children and Reaching Families can give me called “Revocation of Consent for Use and Disclosure of Health Care Information”; or
  - Writing, signing, and dating a letter to Serving Children and Reaching Families, LLC. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient’s personal health information for treatment, payment, and health care and services operations.
- VII. I understand that I must disclose all insurance coverage. If failure to disclose results in a denied claim, I will be financially responsible.

**My signature below indicates that I have been given the chance to review a copy of Serving Children and Reaching Families’ “Notice of Privacy Practices.” My signature means that I agree to allow Serving Children and Reaching Families to use and disclose the client’s personal health information to carry out treatment, payment, and health care operations**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian/ legally authorized individual signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient if signed by anyone other than the patient: \_\_\_\_\_