# SHARON HARGRAVE, MFT, AZ #15489, CA#47921, TX #4459
# Licensed Marriage and Family Therapist

## EFFECTIVE APRIL 14, 2003

**Patient Consent Form to Release Information**
The misuse of Personal Health Information (PHI) has been identified as a national problem causing clients and patients inconvenience, aggravation, and money. Although Amarillo Family Institute, Inc. does not fall under the regulations and privacy rules of the Health Insurance Portability and Accountability Act (HIPAA) directly, the information we give to the management group that administers your insurance program may fall under the HIPAA requirements. Therefore, we want you to know that we strive to prevent improper disclosures of your PHI and make sure you are properly informed of your rights.

**Our Policy Regarding Personal Health Information (PHI)**
We want you to know that we respect the privacy of your personal medical and therapy records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to professionals, health care organizations and health insurance providers in order to secure proper treatment for you or payment of services provided to you.

**Your Right to Your Records**
We also want you to know that you have full access to your personal medical records. If you desire to see or have a copy of your records, you may make the request and we will make every effort to supply the review or copy within 72 hours.

**Your Right to Refuse Release of Personal Health Information (PHI)**
You may refuse to consent to the use or disclosure any or all parts of your Personal Health Information by not signing this form. Further, you may withdraw your previous consent to use or disclose your Personal Health Information at any time, but such a request must be made in writing. Please understand that if you withdraw previous consent, you cannot revoke actions that have already been taken which relied on your previous signed consent.

**Our Right Regarding Refusal of Consent**
If you refuse to consent to disclose your Personal Health Information (PHI), we will be unable to work with other health professionals, organizations, or insurance providers. Without your consent, therefore, we are forced to exercise our right to refuse treatment unless you plan to pay for services completely on your own.

I have read and understand the above information. Further, I give my consent to release my Personal Health Information for the purposes stated above.

Print Name: _____ Date: _____

Signature: _____