xplor counseling
377 Keahole St. E211-d, Honolulu, HI 96825 (808)343-0093

Consent to use and disclose your health information (HIPAA)

This form is an agreement between, _____and Xplor Counselng. When I refer to the word "you", it can apply to you, your child, a relative, or other person if the name is written here_____.

When I examine, test, diagnose, treat, provide services, or refer you to another provider, I will be collecting what the law refers to as Protected Health Information (PHI). I will use this information to decide on treatment/services to provide and to be able to provide you treatment/services. I am also able to use and share this information with others who provide you treatment or to arrange payment for the treatment/services I provide or other business/government functions.

By signing below, you agree to let me use this information here and send it to others such as your insurance company. The Notice of Privacy Practices explains in more detail your privacy rights and how I can use and disclose your information. Please make sure to read this notice before signing this Consent form.
If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, I cannot treat you.

In the future, I may change how I use and share your information so I may change our Notice of Privacy Practices. If I do so, I will provide you an updated copy.

If you are concerned about some of your information, you have the right to ask me not to share some of your information for treatment, payment, or administrative purposes and will need to tell me what you want in writing. I will try to accommodate your requests; however, I am not required to agree to these limitations, but if I do agree, I will honor our agreement unless I are unable to by law.

After you have signed this request, you can revoke your consent by writing a letter to me informing me of your wishes. I will comply with your request from that point forward but will be unable to change or revoke the information that has already been shared. Please be aware that if you revoke your consent, I will be unable to continue providing treatment or services to you.

Please <u>initial</u> to give consent regarding ways that Xplor Counseling may leave PHI:

_____Email _____Text _____Voicemail _____Mail

□ _____I HAVE BEEN GIVEN A COPY OF THE Notice of Privacy Practices/KNOW WHERE TO FIND ONLINE
Client initials

_____
Signature of client or personal representative Date

_____
Signature of client or personal representative Date

_____
Relationship to client/Description of personal representative's authority

_____
Signature of authorized representative of this practice