Robert Jason Grant Ed.D AutPlay Therapy Clinic
(Adult) Notice of Privacy/Informed Consent Form

This notice describes how health information about you and/or your family may be used and disclosed and how you can get access to this information. There are some situations in which we may disclose to other persons or entities your confidential health information; certain disclosures will require you to sign an acknowledgment that you received this notice. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or health care operations requires you to sign an authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your acknowledgement or authorization. These include: 1) Threat of suicide or harm to self or others. 2) Report or suspicion of child abuse or neglect. 3) Court ordered testimony. Under any circumstance, we will disclose only the minimum amount of information necessary for your health records to accomplish the intended purpose of the disclosure.

Notice to use or disclose your confidential health information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.
Treatment: We will use your health information to make decisions about the provision, coordination or management of your health care, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may be necessary to consult with other health care provides inside or outside of this clinic in respect to your treatment.
Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services to be rendered to you. This may include pre-authorization reports, progress reports, treatment plans, and diagnostic assessments.
Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.
Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.
Communication Barriers and Emergencies: We may disclose or use your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment that you intend to consent to use or disclose under the circumstances. We may also use or disclose your protected health information in an emergency treatment situation.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific authorization, which may be revoked at any time.

You have certain rights regarding your health information as follows:
- You may request that we restrict the uses and disclosers of your health information for treatment, payment, and operations, or restrictions involving your care and payment related to that care. We are not required to agree to the restrictions; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make full disclosure without restriction.
- You have the right to request receipt of confidential communications of your health information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address, method of contact, and how payment will be handled.

- You have the right to inspect, copy, and request amendments to your health record. Access to your health information will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
- All requests for inspection, copying and/or amending information in your health record, and all requests to you under this notice, must be made in writing. We will respond to your request in a timely manner.

I, _____, hereby release my health information for discussion of my care and treatment or payment to the family members/friends specified below:

Name	Relationship to Client	Phone
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NOTE: This form does not give the above referenced persons permission to make health care decisions for the client. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the client has given permission/ authorization, or if it is reasonable to infer that the client does not object such as when a client brings a family member or friend into the office when treatment is being discussed.

May we contact you by phone? ☐Yes ☐No

May we contact you by text message? ☐Yes ☐No

May we leave a message on your answering machine/voice mail? ☐Yes ☐No

May we leave a message with another person at your phone number? ☐Yes ☐No

May we contact you by mail? ☐Yes ☐No

May we contact you by email? ☐Yes ☐No

I herby consent to receive mental health treatment and/or evaluation as deemed appropriate by the therapist. I further understand that I am encouraged to discuss said evaluation and/or treatment, including fees, at any time. I also understand that I may refuse to participate in the evaluation or treatment at my discretion. Having read and understood this notice of privacy practices and consent for treatment, I herby consent to treatment, agree to these limits of confidentiality, agree to pay for outpatient services rendered, and agree to all the terms set forth herein. All items have been explained, and, if I request, I have received a copy of this form.

Client Name	Client Signature	Date

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