2200 Main Street #519, Wailuku, HI 96793 (808) 205-4489

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Who Will Follow This Notice

This Notice describes the privacy practices relating to protected health information ("PHI") followed by the doctor, including but not limited to: Dr. Thomas Chen, Psy.D. and all of the employees and staff of Maui Christian Counseling. The doctors, the office employees and staff may share your medical information with each other for treatment, payment of health care operations purposes described in this Notice.

B. Understanding Your Health Record/Information

Each time you visit a physician, hospital or other healthcare provider, a record of your visit is typically made. This record generally contains your symptoms, examinations and test results, diagnosis, treatment and plan for future care or treatment. This information serves as a basis for planning your care and treatment; a means of communication among the doctors and other healthcare providers that are involved in your care; a medical-legal document describing the care you have received; a means by which you or a third-party can verify that services billed were actually provided; a source of data for medical research, education and data collection; a source of information for public health officials charged with improving community health and other healthcare operations.

C. Our Policy Regarding Medical Information

We understand that medical information about you and your health ("PHI") is personal. Our commitment to you is to protect medical information about you. Our office creates a record describing the care and services you receive at our office. This record is necessary in order to provide medical care to you and to comply with certain legal requirements. This notice applies to all of the records created in our office in connection with your care and treatment, whether made by the doctor and/or the employees and staff.

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PATIENT CONSENT TO NOTICE OF PRIVACY PRACTICES

In Accordance with the *Health Insurance Portability and Accountability Act* (HIPAA), you have been provided with our Notice of Privacy Practices that provides information about how we may use and disclose protected health information ("PHI") about you. The notice provides a more complete description of information uses and disclosures.

As part of your healthcare, we maintain health records that describe your health history, symptoms, examinations and test results, diagnosis, treatment and plans for future care or treatment. This information serves as a basis for planning your care and treatment; a means of communication among other health professionals who contribute to your care; a source of information for applying your diagnosis and healthcare information to bill third parties; a means by which a third-party payer can verify that services billed were actually provided; and a toll for routine healthcare operations such as assessing quality and reviewing the delivery of medical services.

You have the right to review our Notice before signing this consent. As provided in our Notice, the terms of our notice and/or privacy practices may change. If we change our Notice and/or privacy practices, we will provide you with a revised copy by mailing it to your then-current address.

You have the right to object to the use of disclosure of your health information. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations in accordance with the Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial {_____} I request the following restrictions to the use or disclosure of my health information:

I have received and read the Notice of Privacy Practices and consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described therein.

_______________________________ _______________________________

Signature Date

Maui Christian Counseling

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ACKNOWLEDGEMENT OF RECEIPT

I, ____________________________, hereby acknowledge that on _________________, I received copies of the following documents:

1) **NOTICE OF PATIENT INDIVIDUAL RIGHTS.**
2) **NOTICE OF PRIVACY PRACTICES.**

DATED: ________________________________

SIGNED: ________________________________