Summit Wellness Centers, PLLC

PO Box:
211 Arden, NC 28704

Client Information Survey (Completed by Client)

In order to better serve you, please clearly print the following information.

Date: _____

Client Name:_____ Sex:_____ M _____ F

Home Address: _____ Date of Birth:_____Age: _____

_____ Marital Status: _____ Years Married:____

E-mail Address: _____

Phone Number (H): _____(cell):_____

May we leave you a message at any of these phone numbers? _____Yes_____No

If no, please specify how you would like us to contact you. _____

You can receive appointment reminders to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments. You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit www.schedule.care to schedule or reschedule your appointments, or send a message to your counselor. Appointment information is considered to be "Protected Health Information" under HIPAA. By providing the information above, I signify that I am choosing to **"opt-in"** to communications via the methods specified above. I understand that email and standard SMS messages are not confidential methods of communication, and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my mental/ behavioral health care may be intercepted and read by a third party. Accordingly, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above. I understand that I can opt-out of receiving communications at any time by contacting the office or speaking with my counselor.

If the client is a child/adolescent, who has legal custody? (*If joint custody, a signed agreement must be completed by both guardians. Please speak with office for this agreement prior to first appointment).

School Information: School: _____ Grade Level:_____

Special Educational Placements: _____

List other family members/significant others living in the home:

Name	**Age**	**Relationship to Client**
_____	_____	_____
_____	_____	_____
_____	_____	
_____		
_____	_____	_____
_____	_____	_____

List other children not living in the home:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Work/School

Current Employer/School _____ Location _____

If in school or college, Current Grade/Year _____ Highest grade ever completed _____

Please explain any problems/concerns with Work/School (change of jobs/schools, firing, suspensions, grades, etc…)

_____

_____

HEALTH

Client Physician/Pediatrician: _____ Phone Number:_____

Date of last appointment with any doctor: _____

Date of last complete physical exam: _____

Current Health:_____ good _____ fair _____ poor

Explain:

Have you ever experienced/been diagnosed with any of the following and if so when?

Arthritis_____	Cancer_____	Diabetes_____	Hearing/Vision Pr._____
Heart Disease_____	Brain Injury_____	High/Low Blood Pressure_____	Kidney Disease_____
Stroke _____	Seizures _____	Fainting Spells_____	Lung Problems_____
Cirrhosis_____	Infertility_____	Low Blood Sugar_____	STD's_____
Thyroid _____	Pancreatitis_____	Migraines _____	Eating Disorder_____
Weight gain/loss _____		Alcohol/Drug Use _____	Other_____

Do you have other medical concerns not mentioned? (Please list other health problems, surgeries, limitations, or disabilities): _____

_____

Is client pregnant? ____**Y / N** Due date: _____

Please note any important medical or mental health problems in your *family*: _____

_____

_____

If client is a child/adolescent, please note any concerns/abnormalities with pregnancy, birth or childhood development:_____

_____

Medications:

If you are presently taking any medications, please complete graph below:

Name	Dosage	Frequency	Start Date – End Date	Reason/Effectiveness	Prescribed By

Do you take your meds as prescribed? __Y __N If no, please explain:_____

_____

_____

Substance Abuse

Has anyone *in your family* had a history of alcohol/drug use? ____Yes ____ No

If yes, explain:_____

_____

Please describe ***your*** history or current abuse of the following substances:

(include age of first use, current frequency, date of last use, and average monthly cost)

Alcohol:_____

_____

_____

Drugs:_____

_____

Prescription Meds:

Has drinking and/or drug use ever caused you problems in the following areas (please circle):

Family School Employment Legal Emotional Relational Health

Legal

Please tell us about any previous or current legal or court involvement (ie. Arrests or pending charges):

Previous Treatment

Have you ever received any type of *outpatient* mental health counseling in the past?

If so, where, and what was the outcome?

Have you ever seen another clinician in our center?

Please list any previous *inpatient* mental health or substance abuse treatment:

Facility Name/Location	Date	Reason	Response to Treatment

Trauma History

Do you have a history of physical, emotional, or sexual abuse, domestic violence, or physical trauma?

If yes, please briefly explain (your counselor will discuss further):

Beliefs

What is your belief about God?

Do you currently attend a church? If so, where?

Family History:

What words would you use to describe the family you grew up in?

Relationships

What concerns do you have regarding current relationships?_____

_____

_____

_____

Today's Appointment

Explain in your own words why you have made this appointment today (your counselor will discuss this with you in more detail):_____

_____

_____

_____

_____

_____

On a scale of 1-10, how do you estimate the current severity of this problem/concern? _____

(1=Mildly upsetting, but tolerable 10= Incapacitating, not tolerable)

What is your goal of treatment?_____

_____

_____

_____

_____What action(s) have you already taken regarding this issue?_____

_____

_____

_____

What do you perceive to be your strengths/abilities that will assist you in the process of achieving your goal?

_____

_____

_____

What personal weaknesses or vulnerabilities may hinder your success? _____

_____

_____

_____

How did you hear about our counseling center or the specific counselor that you are seeing today?_____

_____

_____

_____*Other information you feel is important that wasn't asked about:_____

_____

_____

Summit Wellness Centers, PLLC

PO Box:
211 Arden, NC 28704

Health Insurance Portability Accountability Act (HIPAA)

Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying

with federal privacy law. Additionally, we are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim. I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the North Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the North Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment*** - We use and disclose your health information internally in the course of

your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.

- ***For Payment*** - We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
- ***For Operations*** - We may use and disclose your health information within as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Patient's Rights:

- ***Right to Confidentiality*** - You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** - You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** - If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.
- ***Right to a copy of this notice*** - If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** - If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.

- ***Right to Choose*** - You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** - You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** - With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

Disclosure to Health Information Exchanges: (For NC State Health Insurance Plans)

This facility participates in the North Carolina Health Information Exchange Network, called NC HealthConnex. which is operated by the North Carolina Health Information Exchange Authority (NC HIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from North Carolina programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthCOnnex not paid for with state funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC Health Connex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthCOnnex are available in our offices and online at NCHealthConnex.gov. You may also contact our Privacy Office at (828)-692-6383. Again, even if you opt out of NC HealthConnex, we will submit your PHI if your health care services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHealthConnex.gov/patients.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of North Carolina Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Legal Guardian Signature Date

_____ _____

Printed Name

_____

Client/Legal Guardian Signature Date

_____ _____

Printed Name

_____

Kevin Wimbish, LMFT, HIPAA Compliance Officer

Professional Disclosure Statement

Kristi James, Student Intern
Summit Wellness Centers, PLLC
PO Box 211
Arden, NC 28704
Phone: (828) 692-6383
Fax: (828) 692-6748
www.summitwellnesscenters.com

I look forward to being your counselor with Summit Wellness Centers, PLLC. This document is meant to inform you about my preparation as a counselor-in-training, information about our professional therapeutic relationship, your rights and responsibilities as a client, and the limits of confidentiality.

Education/Licensure:

I have a bachelor's degree in psychology from DePauw University and am currently pursuing a Master's in Christian Counseling from Gordon Conwell Theological Seminary. Upon completion in 2024, I will pursue licensure as a North Carolina Licensed Clinical Mental Health Counselor. I currently practice as a student intern under the supervision of a Licensed Clinical Mental Health Counselor (Lori Heagney, MS, LCMHC). I have also completed core counseling courses, including Introduction to Counseling, Helping Relationships, Psychopathology, Ethics, Assessments, Multicultural Diversity in Counseling, Family Systems Theory, Group Dynamics, Career Counseling, Lifespan Development, and Advanced Trauma Diagnosis and Treatment.

As a student intern at Summit Wellness Centers, PLLC, I will receive one hour of supervision from my designated supervisor, and I will also attend 1.5 hours of group supervision from a Gordon Conwell Theological Seminary counseling department faculty member. Audio and visual recordings are a required aspect of my weekly supervision and will only be reviewed by my designated supervisors and fellow student supervisees assigned to my seminary supervision group. Consent is required for participation in these recordings, and once my counseling internship is completed, all recorded content will be destroyed.

Counseling Background:

In my practice, I offer services to individuals, couples, and families. I counsel from a person-centered approach, focusing on each client's unique needs in a nonjudgmental environment. I incorporate techniques from Cognitive Behavioral Therapy and Internal Family Systems as well. Cognitive Behavioral Therapy focuses on identifying thoughts, feelings, and behaviors, challenging irrational thoughts, and reframing client beliefs to create change in emotions and behaviors. Internal Family Systems is an approach that seeks to grow self-compassion and understanding by connecting with internal "parts" of ourselves. Together,

we will set goals for treatment and determine which methods will work best for your concerns. You are always welcome to ask questions and discuss my approach.

Use of Diagnosis:
Diagnoses may be used in order to offer the best care in services. The purpose of diagnosis is to define the problem, not the person. Diagnoses will influence treatment goals and modalities. All diagnoses issued by the counselor will be placed as a permanent record on the client's personal files. If a qualifying diagnosis is appropriate in your case, I will inform you.

Fees and Services:
Individual and family sessions are generally 50 minutes in length, and group sessions are generally 90 minutes in length. The appointment fee for student interns is $75/session and is self-pay only. Please contact our billing department with any questions (828-692-6383). Payment is due at the conclusion of each session. Any questions or concerns should be directed to the counselor during intake or in the first few sessions.

If for any reason you must cancel an appointment, please call at least 24 hours prior to the appointment. Otherwise, you will be charged for the time that is reserved for you (the no-show fee for a student intern is $75).

Telehealth:
Telehealth services may be provided through a HIPAA-compliant, encrypted portal. All confidentiality guidelines, laws, treatment expectations, and fees for face-to-face treatment, as described elsewhere in this document, also apply in the venue of telehealth.

Termination of Services:
Termination may occur for a variety of reasons, including:

- Attainment of treatment goals
- Verbal or written notification by the client
- Failure to make required payment
- Missing 3 or more appointments without rescheduling within 3-month time period (per agency's cancellation policy)
- Threatening remarks or actions toward the counselor
- Completion of required number of counseling sessions mandated by program or court

If contemplating termination, please consider consulting with your counselor.

Confidentiality:
Trust is the cornerstone of the counseling relationship. Every client has the right to expect confidentiality, beneficence (serving the client's best interest), and fidelity (loyalty to the client) in the counseling session.

I am committed to maintaining confidentiality for what is shared during counseling sessions. Per the North Carolina Board of Licensed Professional Counselors, the following are exceptions to confidentiality or privacy:

- a person threatens to harm themselves or others
- if I suspect child or elder abuse/neglect,
- a court orders a release of records

As I work with children, I encourage communication with families and other important stakeholders (with releases of information) while balancing this with the client's right to confidentiality in the counseling process. Additionally, I will discuss my clinical work with my clinical supervisor, who abides by the same rules of confidentiality listed above.

Complaints:
If you are unhappy with our professional relationship, I encourage you to discuss your concerns with me. If that does not suffice, you may contact my supervisor, Lori Heagney, MS, LCMHC, at Summit Wellness Centers, PLLC (828-692-6383). I abide by the ACA Code of Ethics (https://www.counseling.org/resources/aca-code-of-ethics.pdf). You may also file a complaint with the organization below provided you feel I am in violation of these codes of ethics.

If you would like to register a complaint, please contact:
North Carolina Board of Licensed Professional Counselors
PO Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblpc.org

Acceptance of Terms

I understand and agree to the preceding information regarding the counseling process, confidentiality privileges and limitations, and the fee requirements, and I understand I have the right to terminate therapy at any time.

I consent to audio/video recordings and/or live supervision as described above.

By signing below, the client or parent/legal guardian 1) acknowledges that he or she has read the information above and has had any questions regarding its contents explained and 2) agrees to allow counseling services to be provided.

Client:_____ Date:_____

Parent/Guardian:_____ Date:_____

Counselor: _____ Date:_____

Summit Wellness Centers, PLLC

Payment Policy:

It is the policy of Summit Wellness Centers, PLLC that **PAYMENT IS DUE AT THE TIME OF SERVICE.** In order to complete this process efficiently, Summit Wellness Centers, PLLC will maintain secure records of our clients' credit /debit card. **If you are self-pay, your card will automatically be billed at the time of the service. If you are using insurance, your card will automatically be billed at the time of service for the estimated deductible, copay and/or coinsurance payment. Your card will also automatically be charged fees for no-show/late-cancellation appointments (including initial intake appointments).** You are responsible for keeping an updated card on file, and are responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend you also contact your insurance carrier and inquire regarding your behavioral health benefits, and if there is an out-of-network carve-out for behavioral health services.

By paying via credit/debit card, you acknowledge that this credit/debit card information will be automatically kept on file via PCI-compliant encrypted code with the following credit card processor: TSYS (CAYAN). Health Savings Account cards can be kept on file as the primary form of payment, but there must be a back-up credit/debit card on file in case HSA funds are depleted.

Cancellation/No-Show Policy:

If for any reason you need to cancel an appointment, including intake appointments, you must call at least 24 HOURS prior to the appointment to reschedule. Otherwise, you will be charged for the time that was reserved for you ($150 for a late-cancel/no-show intake or $140 for a late-cancel/no show follow-up session). If you repetitively cancel appointments, we reserve the right to discontinue services. Because of high demand for our services, we keep a waiting list of those who are waiting for an opening. This cancellation and no-show policy assures that we are being good stewards of the availability and time reserved for our counselors, thereby allowing us to best serve our clients. We appreciate your cooperation and partnership in this matter as we seek to serve our community. In an effort to prompt reminders and mitigate no-show/late cancellations and associated fees, we offer clients the option of automated appointment reminders 48 hours in advance.

Signed Agreement:

I (we), the undersigned, authorize and request Summit Wellness Centers, PLLC to charge the credit/debit card, which I provide, for any balances due for services rendered that my insurance company identifies as my financial responsibility. If uninsured, or in the event of no-show appointments, I authorize Summit Wellness Centers, PLLC to charge my credit/debit card for my balance due. This authorization will remain in effect until I(we) cancel this authorization. To cancel, I(we) must give a 60 day notification to Summit Wellness Centers, PLLC in writing and the billing account must be in good standing.

Client Name _____ Date _____

Client Signature _____

Updated 1/1/2024

Summit Wellness Centers, PLLC

REGISTRATION AND INSURANCE INFORMATION

Today's Date: _____
Client: _____ **DOB:** _____ **Age:** _____

Client Social Security Number (for insurance purposes only): _____
Social Security Number of the insured: _____ DOB of insured: _____
Spouse Name: _____
Parent/Guardian Name: _____
Address: _____
_____

Telephone: (H): _____ (W): _____ (C): _____
Emergency Contact Person: _____ Phone: _____

Insurance Information

Are you covered by health insurance? (circle) Yes No

	Primary Insurance	Secondary Insurance
Name of Insurance:	_____	_____
Insured's Name:	_____	_____
Insured's Social Security #:	_____	_____
Insured's Date of Birth:	_____	_____
Policy # / Group #:	_____	_____
Relationship to Client:	_____	_____

Note: We will file insurance claims for you. However, you are responsible for any deductible, non-covered charges, or co-payments which may apply. This responsibility, due at the time of service, is a result of your contract with your insurance company. Refusal to pay your contractual obligation is fraudulent. As a courtesy, we will verify your insurance benefits. However, we recommend that you also personally verify your behavioral or mental health benefits with your insurance company. In the event that insurance payments differ from the information we receive from your insurance company, you will be billed for any remaining balance owed. Being referred to our clinic by another physician does not guarantee that your insurance will cover our services.

I authorize any holder of medical or other information about me to release Social Security Administration, any Health Care Financing Administration or its intermediaries or carrier of any other commercial insurance company, any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Summit Wellness Centers.

Client Signature: _____ Date: _____

Summit Wellness Centers, PLLC

Authorization to Release/Exchange Confidential Records and Protected Health Information

Client: _____ **Date:** _____

I hereby authorize *Summit Wellness Centers* to disclose/obtain/exchange mental health treatment information and records obtained in the course of treatment of client, including, but not limited to, provider's diagnosis of client, to/from/with the person(s) below: (both parties have my permission to exchange information regarding my treatment).

(List individual/office/facility)

Name: _____ **Relationship:** _____

Address: _____

Phone Number: _____

This authorization may include the following exchange of information: (please *circle* individual items below only if you are limiting areas you want to identify for release. Otherwise, all below areas are included in this release and it is not necessary to circle. Summit only releases the minimum amount necessary per request). Referral information, relevant history or diagnoses, treatment planning, evaluation results, continuity of care, insurance information, Inpatient and/or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse, treatment notes and summaries, treatment plans, social histories, assessments, recommendations, and similar documents, information about how the client's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work, and billing records. When requested of information, Summit only releases minimum information necessary to complete requests; typically in the form of a brief letter with dates of treatment and summary of progress.

Circle if this release is for billing purposes only: **Billing Only**

Please explain below any additional limitations to this release (anything you do not want Summit to release):

_____

_____

Communicable diseases, HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated by your initial here: _____ Do not release.

I understand that no services will be denied to me/the client solely because I refuse to consent to this release of information, and that I am not in any way obligated to release information. I do sign this release because I believe that it is necessary to assist in the development of the best possible treatment plan for me/the client. The information disclosed may be used in connection with my/the client's treatment. The purpose of the release may include continuation of care, legal purposes, or insurance purposes.

In consideration of this consent, I hereby release Summit from any and all liability arising from the release. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule.

I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire one year from the date below.

I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

_____ _____

Client / Parent / Guardian Signature Date

_____ _____

Witness Signature Date