

Counseling Center For Emotional Growth
5225 Old Orchard Road
Suite 29
Skokie, Illinois 60077
Phone 847-967-0952 Fax 773-248-5324

Client Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in the treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal health care operations such as quality assessments and physician certifications.

I have been given a copy of CCFEG's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health care information. I have been given the right to review such Notice of Privacy Practices Prior to signing this consent. I understand that CCFEG has the right to change its Notice of Privacy Practices from time to time, and that I may contact CCFEG at any time, at the address above, to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that CCFEG restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that CCFEG and my therapist are not required to agree to my restrictions, but if agreed to, they are then bound to abide by such restrictions.

I understand that I may revoke this consent, in writing, at any time, except to the extent that CCFEG, or my therapist, has taken action relying on this consent.

Client Name: _____ Client Signature: _____

Date: _____ Guardian Name: _____ Relationship: _____

Guardian Signature: _____

