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## FACT SHEET REGARDING CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The attached consent form permits [Matthew Wofsy, LCSW], to disclose the following protected health information [PHI]:

**(1)** demographic information about you, such as name, address, telephone number, e-mail address, gender, marital status, social security number, medical insurance plan number, etc.;

**(2)** progress notes, which include: **(a)** the dates, times, types and frequencies of clinical services rendered to you, **(b)** your diagnoses, **(c)** your prognosis, **(d)** information about your mental and functional status and symptoms, and **(e)** summary information regarding the general themes, issues, symptoms and problems being addressed in your counseling/therapy in general terms [for instance, addressing particular symptoms, feelings, thinking processes, beliefs or behaviors such as pain, anxiety, avoidance, etc.; relating to specific relationships or situations such as a work problems, interpersonal relationships, parent-child problems, marital relationship, school problems];

**(3)** the results of psychodiagnostic or other clinical tests administered to you;

**(4)** medications your are taking, and the monitoring of your response to the medication and any side effects of the medication that you may experience;

**(5)** your treatment or service plan and revisions of that plan, including the names of the providers and the nature of services being provided to you by other health care professionals; and

**(6)** assessment of your progress in therapy;

as may be necessary for the purpose of **treatment**, **payment**, and **health care operations**.

This consent does not authorize the disclosure by [Matthew S. Wofsy, LCSW] of psychotherapy notes relating to you, which are the notes recorded by a mental health professional, such as me, documenting or analyzing the contents of conversations during private individual therapy sessions. Psychotherapy notes, as contrasted with general progress notes that include items noted in the preceding paragraph, are held to a higher standard of privacy protection because they are not part of the general clinical record and are not intended to be shared with anyone else in a form which would identify that information as relating to a particular patient or client. For this reason, psychotherapy notes are separated from the rest of a patient or client's clinical record.

**Treatment** refers to [Matthew Wofsy, LCSW]: **(1)** providing specific health care services to you including but not limited to assessment, diagnosis, and psychotherapy; **(2)**

consulting with other health care providers who are providing health care services to you in order to coordinate the care being provided to you; **(3)** referring you to another health care provider for other health care assessment, diagnostic or treatment services.

**Payment** refers to activities undertaken by [Matthew S. Wofsy, LCSW] to obtain reimbursement for the provision of mental health services to you; this includes: **(1)** determinations of your health plan eligibility or coverage, including coordination of benefits; **(2)** billing, claims management, collection activities for services rendered to you; **(3)** review of mental health services rendered to you with respect to clinical/medical necessity of services and justification of charges; **(4)** utilization review activities and pre-certification/pre-authorization of services in relation to services to be provided or being provided to you; and, **(5)** disclosure to consumer reporting agencies limited to any of the following information about you relating to collection of reimbursement; **(a)** name and address; **(b)** date of birth; **(c)** social security number; **(d)** payment history; **(e)** account number; and **(f)** name and address of the health care provider and/or health plan.

**Health care operations** refers to various activities that are required to manage and conduct my practice. Examples of these are quality assurance reviews, training and supervising persons who work for me, and arranging for accounting, billing, legal and other practice management related services. When I use persons or organizations who are not part of my workforce to provide these services, I have a business associate agreement with these persons or organizations by which they agree to protect the confidentiality, privacy and security of the PHI I disclose to them to the same extent that I am required to do so.

To the extent that I disclose protected health information about you pursuant to this consent. I will make reasonable efforts to limit the use or disclosure of protected health information **to the minimum necessary to accomplish the intended purpose of the disclosure**, unless the disclosure is to another health care provider who is providing you with assessment, diagnosis or treatment, or to whom I am referring you for assessment, diagnosis or treatment.

Although I no longer have control over the PHI I disclose to another health care provider or health plan: **(1)** licensed health care providers in New York are required to protect the confidentiality of PHI disclosed to them and are subject to professional misconduct proceedings and civil lawsuits if they fail to do so; **(2)** all health plans are required by federal law to maintain the confidentiality of PHI which is submitted to them and can be subject the both civil and criminal penalties if they fail to do so; and **(3)** my business associates are legally bound to safeguard the privacy, confidentiality and security of the PHI which I disclose to them.

This consent will be valid until I cease providing mental health services to you or until I receive from you your written revocation of all or part of this consent. Your partial or total revocation of this consent will not apply to any action which I have taken in reliance on this consent prior to receiving your written revocation of all or part of this consent. Also, to the extent that this consent permits the disclosure of PHI for the purposes of payment, this consent will be valid for the disclosure of any PHI related to services I rendered up until the time I receive your written revocation of consent, even if such disclosure is made after your written revocation. In other words, your written revocation will not apply to disclosures made after the date I receive it if those disclosures relate to services I provided prior to my receipt of your written revocation.

I am permitted by law to require your consent as a condition of my agreeing to provide or to continue to provide mental health services to you.

## CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, hereby consent to the disclosure by [Matthew S. Wofsy, LCSW], of protected health information [PHI] as described on the attached fact sheet about _____ as follows (initial each statement to confirm your consent):

For the purpose of treatment: related to _____:

_____ 1) to any health care professional who is providing him/her with concurrent care who requests such information to aid in that health care professional's assessment, diagnosis and treatment of him/her;

_____ 2) to any health care professional to whom [Matthew Wofsy, LCSW] may refer him/her so that the referral can be made properly and the care they provide to him/her can be coordinated properly;

_____ 3) to any mental health professional who is providing him/her with concurrent mental health services so that those services can be coordinated properly with the services being provided by [Matthew Wofsy, LCSW];

_____ 4) to any physician or nurse practitioner who is providing him/her with concurrent medical services so that those services can be coordinated properly with the services being provided by [Matthew Wofsy, LCSW].

For the purpose of payment for services rendered to: _____:

_____ 1) to any health plan to verify benefit eligibility;

_____ 2) to any health plan for the purpose of obtaining pre-authorization or continued authorization for services;

_____ 3) to any health plan for the purpose of submitting a claim for reimbursement for services rendered by [Matthew Wofsy, LCSW];

_____ 4) to any health plan to conduct reviews or audits of patient records for the purposes of (a) making a determination of clinical/medical necessity under the plan, (b) determining appropriateness of charges or services under the plan, and (c) for fraud control auditing.

For the purpose of health care operations of: [Matthew Wofsy, LCSW]:

_____ 1) to the business associates of [Matthew Wofsy, LCSW] provided that there is a business associate agreement in place between [Matthew Wofsy, LCSW] and the business associate which requires the business associate to safeguard the privacy, confidentiality and security of the PHI which is disclosed to them.

This consent will be valid until [Matthew Wofsy, LCSW] ceases providing mental health services to me (or the person for whom I am signing this consent) or until [Matthew Wofsy, LCSW] receives from me written revocation of all or part of this consent.

My revocation of this consent will not apply to any action [Matthew Wofsy, LCSW] has taken in reliance on this consent prior to receiving my written revocation of all or part of this consent.

Also, to the extent that this consent permits the disclosure of PHI for the purposes of payment, this consent will be valid for the disclosure of any PHI related to services [Matthew Wofsy, LCSW] rendered until the time [Matthew Wofsy, LCSW] received my written revocation of consent, even if such disclosure is made after my written revocation. In other words, my written revocation will not apply to disclosures made after the date [Matthew Wofsy, LCSW] receives it if those disclosures relate to services [Matthew Wofsy, LCSW] provided prior to my receipt of my written revocation.

Dated: _____/_____/_____

_____
Signature of patient (or parent/guardian)

Witness: _____
[Matthew Wofsy, LCSW]