NORTH STAR COUNSELING HIPAA POLICY

I understand that North Star Counseling (NSC) may use my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that NSC will consider requests for restriction on a case-by-case basis. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. Release of personal information other than as explained above shall only occur by separate written authorization.

HIPAA ACKNOWLEDGEMENT

I have read the HIPAA Policy and I understand that I may request a copy of it.

I consent to receive treatment from a provider at North Star Counseling for myself/my dependent.

Signed _____

Date _____

Witness _____