Kairos Counseling Services
Patient Acknowledgement of Receipt of
Notice of Privacy Practices
And consent/Limited Authorization &
Release form to Obtain & Release Records And
Consent Form to Disclose Health Information &
Coordination of Care

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this office. A copy of this signed, dated document shall be as effective as the original. Date: ________________
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

____ ____
Please **print** name of Patient Please **sign** for Patient / Guardian of Patient

____ ____
Legal Representative/ Guardian Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
□ First Name Only □ Proper Surname □ Other_________________
PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes Primary Care Physicians, parents, stepparents, grandparents and any care takers who can have access to this patient's records):

Name:______________________ Relationship:________________ Contact PH #: _________________

Name:______________________ Relationship:________________ Contact PH #: _________________

Name:______________________ Relationship:________________ Contact PH #: _________________

Name:______________________ Relationship:________________ Contact PH #: _________________

Name:______________________ Relationship:________________ Contact PH #: _________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

□ Cell Phone Confirmation □ Home Phone Confirmation □ Email Confirmation

□ Work Phone Confirmation □ **Any of the Above** □ Text Messages

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

□ Cell Phone Confirmation □ Home Phone Confirmation □ Email Confirmation

□ Work Phone Confirmation □ **Any of the Above**

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend services to promote your improved health. This office may or may not receive third party remuneration from the affiliated companies. We, under the current HIPAA Omnibus Rule, provide you with this information with your knowledge and consent. I hereby request that health and mental health information may be discussed with and disclosed to the family members and relatives, school officials, friends and other providers, including therapists and physicians. The individuals identified below are involved in my care and/or payment of my care and agree that the provider listed above may share such information as the provider may deem relevant to such individual involvement. Including appointment times, required care, and diagnosis, I understand that I have the right to revoke this request/consent by delivering written notice to the provider.

This is for coordinating care; my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my primary care physician and or another mental health provider. I hereby authorize the use or disclosure of my individual identifiable health information. This release shall be valid (60 days) after my last date of treatment or until I revoke this release.