



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the CoveCare Center's Notice of Privacy Practices.

Client Name (Print)

Client Signature

If completed by a client's personal representative, please print and sign your name in the space below

Personal Representative (Print)

Personal Representative's Signature
Relationship

For CoveCare Center use only

Complete this section if this form is not signed and dated by the client or client's personal representative.

I have made a good-faith effort to obtain a written acknowledgement of receipt of the CoveCare Center Notice of Privacy Practices but was unable to for the following reason:

- Client refused to sign
- Client unable to sign
- Other

Employee Name

Date

This form should be placed in the client's medical record

Revised 3/29/2019

PERMISSION TO TREAT A MINOR

Childs Name: _____ DOB: _____

I am the custodial parent/legal guardian of the above named child. I give permission for any of the CoveCare Center professional staff to provide psychotherapeutic treatment to _____.

Signature

Date

Print Name

Relationship

Witness

Details about patient information in PSYCKES and the consent process:

1. How Your Information Will be Used. Your electronic health information will be used **only** to:

- Provide you with medical treatment and related services
- Evaluate and improve the quality of medical care provided to all patients.

Note: The choice you make in this Consent Form does not allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. What Types of Information About You Are Included? If you give consent _____ may access all of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES includes information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Mental health conditions
- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Sexually transmitted diseases

3. Where Health Information About You in PSYCKES Comes From. If you received health related services that were paid for by Medicaid, information about those services will be stored in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be stored in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. Health information from other databases maintained by NYS is also included in PSYCKES. New health database may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

4. Who May Access Information About You, If You Give Consent. Only these people may access information about you: doctors and other health care providers who serve on _____'s medical staff who are involved in your medical care; health care providers who are covering or on call for _____'s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call _____ at _____; or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. Re-disclosure of Information. Any electronic health information about you may be re-disclosed by _____ to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

7. Effective Period. This Consent Form will remain in effect until 3 years after the last date you received any medical services from _____, or until the day you withdraw your consent, whichever comes first.

8. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to _____. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling _____ at _____. Note: Organizations that access your health information through _____ while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. Copy of Form. You are entitled to receive a copy of this Consent Form after you sign it.