**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR REFERRAL TO CARE CONNECTED TELEPSYCHOLGY COGNITIVE BEHAVIORAL THERAPY (TeleCBT) SERVICES**

**This authorization allows the referring entity written/indicated below to release (PHI) for the purpose of referring interested adult individuals to Care Connected TeleCBT services.**

I, _____ **(Patient Name),** hereby authorize _____ **(Name of Referral Source)** and/or associated administrative and clinical staff to disclose the following information to Care Connected TeleCBT services:

**CHECK ALL THAT APPLY**

____Patient Contact Information

____Presenting Problem

____Psychological and/or Medical Diagnosis

____Treatment Summary

____Psychological Testing Results

____Psychotherapy Notes

____Other (Please Indicate): _____

This information is to be released for the purpose of:

**CHECK ALL THAT APPLY**

____Consultation/Discussion of Services

____Psychological Evaluation

____Psychological Treatment

____Diagnosis

____Treatment Planning

____Coordinate Services

____Other (Please Indicate): _____

## Care Connected TeleCBT Referral Form

Date of Referral: _____ Patient Name: _____

Address: _____ Telephone Number: _____

Date of Birth: _____ Sex: _____

Referrer Name: _____ Job Title: _____

Employer: _____ Business Address: _____

Office Phone Number: _____ Has patient agreed to referral: _____

**Reason for Referral:**

DURATION: This authorization shall be effective immediately and remain in effect until ____/____/_____. (DD/MM/YYYY)

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. I understand that it is my right to revoke this consent at any moment and agree to notify Care Connected or the referring party as soon as possible if I decide to do so.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

My signature below indicates that I understand the information on this form and have been provided with a copy of the Notice of Privacy Practices which explains how Care Connected adheres to safeguarding the privacy and security provisions of medical information as indicated by the Health Insurance and Portability and Accountability Act (HIPAA). By signing this form, I consent for Care Connected to have access to the information I indicated on this form and to be contacted by Care Connected to discuss and initiate my participation in TeleCBT services.

| | |
|---|---|
| Signature of patient *or legal/personal representative* | Relationship *if other than patient* |
| Patient's Name (PRINT) | DATE |
| Patient's Social Security Number | Patient's Date of Birth |
| Witness name | Witness signature |

Please submit completed forms via e-mail or fax to the Care Connected Program Operations Manager & HR Generalist, Luisana Elias.

E-mail: luisana@accesshealthsolution.com
Fax: 858-408-4390

CareConnected

## NOTICE OF PRIVACY PRACTICES

**The Health Insurance Portability and Accountability Act of 1996** is United States legislation that provides data privacy and security provisions for safeguarding medical information. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It should be reviewed with care.

Care Connected TeleCBT Providers and their associates are required by federal and state law to maintain the privacy of your health information, as well as give you this notice about privacy practices, legal obligations, and your rights concerning your health information, "Protected Health Information" (PHI). TeleCBT Providers and their associates must follow the privacy practices that are described herein and these practices may be amended as needs or requirements change. For further clarification of anything noted in this document, please contact Care Connected TeleCBT at 858-249-8565.

TeleCBT providers will make every possible effort to ensure your confidentiality. In addition, when contacting you via phone for TeleCBT sessions, your TeleCBT Provider will take steps to verify your identity (i.e., date of birth or assigned case number). In general, computers, e-mail, and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access because servers have unlimited and direct access to all e-mails that go through them. Care Connected e-mails are not encrypted; however, computers are equipped with firewall and virus protection, a password, and confidential information on company computers is regularly backed up. You agree to notify your provider if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell phone or faxes.

**Uses and Disclosures of Your Protected Health Information:** The following will explain the ways in which your health information may be used ***without your consent*** under Federal and State law. In all cases, TeleCBT Providers practices disclosing minimum information necessary to achieve the purpose of said disclosure. This is not intended to be an exhaustive list, but instead an explanation of cases and scenarios where disclosure of PHI may be necessary falling under general categories. These disclosures exclude psychotherapy notes as described in the next section.

**Treatment:** TeleCBT Providers and their associates may use and disclose information related to your treatment to members of your current treatment team for the purposes of continuity of care and to coordinate and manage your healthcare and related services.

**Payment:** TeleCBT Providers and their associates may use and disclose information in your protected health record for billing purposes with your insurance plan. Your insurer may require certain information about your treatment prior to authorizing payment for services.

**Health Care Operations:** These include quality improvement activities, consultation with colleagues, licensing, and credentialing activities.

**In the event of an emergency, your protected health information may be disclosed in order to allow for your treatment and care. When required by law, your protected health information will be disclosed.**

**Uses and Disclosures Requiring your Written Consent:**

Notes recorded by TeleCBT Providers and their associates, documenting the contents of your session (Session Notes), will be used only by your providers and will not otherwise be used or disclosed without your written authorization. Marketing activities will never include your protected health information without your written approval. Any disclosure to individuals not directly involved in your treatment or care (i.e.: your attorney, school, etc.) will require your written authorization for release of PHI. Your "authorization" to release PHI may be revoked at any time by providing that the revocation be in writing. This revocation will go into effect when the written notice has been personally received and reviewed.

**Your Rights Regarding Your Health Information:**

**Right to Inspect and Copy:** You have the right to inspect and copy your medical and billing records, but not your psychotherapy notes. All requests of this nature must be made in writing. There will be a fee associated with copying records and mailing records if you chose to receive them via mail.

**Right to Request Confidential Communications:** You have the right to request that TeleCBT Providers and their associates communicate with you only in a certain location or through a certain method (i.e. at work only, or through email, etc.) All requests must be received in writing and reasonable requests will be honored. A reason for the request is not necessary, but we do need to know the specifics on where and how you wish to be contacted.

**Right to Request Restrictions:** You have the right to request a restriction on the health information that is used or disclosed about you for treatment, payment, or health care operations. Requests for restrictions must be submitted in writing. We are not required to agree with your requested restriction, however, TeleCBT Providers and their associates will honor your request unless the restricted health information is needed to provide you with emergency treatment.

**Right to Accounting of Disclosures:** You have the right to request to be provided with an accounting of the disclosures that have made of your protected health information. This request must be made in writing and will not include disclosures made for the purposes of treatment, payment, and health care operations.

**Right to Request an Amendment:** You have the right to request amendment of your health information. Your request must be made in writing and should detail the reason for the requested amendment. This request may be denied in certain circumstances.

**Right to a Paper Copy of this Notice:** You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

**Questions or Complaints:** Any questions or complaints regarding your privacy rights should be addressed with the Privacy Officer, your TeleCBT Provider. You may also contact the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against should you choose to complain to TeleCBT Providers and/or their associates, or an outside agency.

**This notice is effective April 14, 2003. It may be amended at any time, and the revision will be effective for all PHI maintained. In the event of an amendment, a new notice will be posted and you may request a copy of the revised notice.**