



Behavioral Health and Education Specialists

24402 West Lockport Street, Suite 218, Plainfield, Illinois 60544

(815) 609-1544

(815) 609-1670 (Fax)

www.bhes.us

Info@bhes.us

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Behavioral Health and Education Specialists (BHES) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of BHES.

I understand that diagnosis or treatment of me by a BHES provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. BHES is not required to agree to the restrictions that I may request; however, if BHES agrees to the restriction that I request, the restriction is binding on BHES and treating professional.

I have the right to revoke this consent, in writing, at any time, except to the extent that my treating professional at BHES has taken action and reliance on this consent.

My "protected health information" means health information, collected from me and created or received by my behavioral health provider, including my demographic information, health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition which identifies me or there is a reasonable basis to believe the information identifies me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of BHES. This Notice of Privacy Practices also describes my rights and the duties of BHES with respect to my protected health information.

BHES reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I understand I have a right to review BHES' Notice of Privacy Practices prior to signing this document and that the BHES Notice of Privacy Practices has been provided to me.

Signature of Patient/Parent or Guardian

Date

Printed Name