

Equality Mental Health, LLC

HIPAA Consent Form

This is to inform you that as required under the federal Health Information Portability Act, no protected health information will be disclosed by me, without your explicit written and signed permission, except where required by law, or for the collection of fees, including your insurance company for the services you received.

You have the right to be notified of a breach of your privacy, and to restrict disclosures of your privacy, and to restrict disclosures of your protected health information when you have self-paid. You may opt out of any fundraising communications.

You may gain access to this information by requesting from Howard Craig Cutler, LCSW, NCPsy.A, Principal of Equality Mental Health.

Complaints regarding these matters should also be addressed to Howard Craig Cutler, LCSW, NCPsy.A, Principal of Equality Mental Health.

Patient's Signature _____

Date _____