The Life Health Center
Wellness is Your Key to Life

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY POLICIES

Client: _____ DOB: _____

The Life Health Center (LHC) operates within the guidelines set forth by the Department of Public Health (DPH).

The law requires that center LHC staff provides specific patient information to DPH for certain reasons:

- To measure disease activity in Delaware and the United States
- To prevent or control disease or injury in Delaware and the United States

Information that will be reported includes: sexually transmitted diseases, laboratory tests about reportable diseases (some infections), deaths, adverse medication reactions, child abuse or neglect.

Information about services that you or your child receives will also be shared with your health insurance.

You can get a copy of you or your child's records by contacting our Medical Records Office at 302-552-3574.

The Life Health Center must follow the HIPAA Privacy Rules. By law we are required to give you with a copy of HIPAA/Notice of Privacy Practices. I understand that if I have any questions, I may call the Wellness Center staff at (302) 429-4083 or LHC medical practice at 302-552-3574.

I have received a copy of the following: (Please Check)

☐ **HIPAA Notice of Privacy Practices**

☐ **Counseling Practice Police and Processes**

☐ **(STAFF ONLY) Completed by telephone**

_____	_____	_____
Name of Adult Client/Legal Guardian	Signature of Adult Client/Legal Guardian	Date
_____	_____	_____
Name of LHC Witness	Signature of LHC Witness	Date
_____	_____	_____
Name of LHC Witness (2) - verbal consent	Signature of LHC Witness (2)	Date

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AUTHORIZATION TO RECEIVE/SHARE INFORMATION

Client Name: _____ DOB: _____

I, _____ (Adult or Legal Guardian Print), do hereby consent authorization for The Life Center Complex, Inc. to (Place an "X") ☐ Obtain Information ☐ Share Information ☐ Verbally Communicate about the client with:

Name of Agency	Department (If available)	Name of Contact Person

Agency Address: Street	Suite	City	State	Zip Code

Agency phone number and fax number

Purpose: This requested information is needed to assist in treatment, evaluation, and continuity of care.

- ☐ List of Medical Records, Immunization Records, Current and Past Medications, Lab Results, and Associated diagnoses
- ☐ Service History and Involvement
- ☐ Verification of custody/guardianship (Under 18 years of age)
- ☐ Psychological Testing Results, treatment recommendations
- ☐ Substance Abuse Testing Results, treatment recommendations
- ☐ Admissions Summaries, Treatment/Service Plans, Discharge Plans, other pertinent clinical
- ☐ Employment Documents
- ☐ Other relevant Clinical or services related documents or Information

(Specify):_____

I understand that:

- Information obtained is prohibited from re-disclosure.
- Information obtained may come from records protected by State, HIPAA, or Federal Law
- Information obtained may contain information pertaining to individual, family, medical, psychiatric, drug, and/or alcohol history, diagnosis, and/or treatment.
- This form is valid and effective for this student through the end of term of the 5th grade unless otherwise revoked by you.

In accordance the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that: This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION only if I print and place my signature on the appropriate line. In the event the health information described below includes any of these types of information, and I initial the line, I specifically authorize release of such information to the person.

Time Limit & Right to revoke authorization: I understand that this authorization is valid for one year from the date of signing or until discharge from The Life Center Complex, Inc. and I may revoke this authorization at any time by notifying the providing organization in writing. Such revocation will not have an effect on any actions taken by the providing organization prior to their receipt of my revocation request. I also understand that by signing this release below, I am also authorizing The Life Center Complex, Inc. to verbally consult/communicate directly with the above organization until discharge from The Life Center Complex, Inc.

_____ _____
Minor client (Print and Signature) Date

_____ _____
Adult Client or Legal Guardian if a Minor (Print and Signature) Date

_____ _____
LHC Employee (Print and Signature) Date